Zaheer Pediatric Associates, S.C.

70 Meadowview Center, Suite 300 Kankakee, IL 60901

Patient Registration

PATIENT INFORMATION

Patient name ____

Date of Birth ________________________ Sex: ☐ M ☐ F Social Security # ____________________

Address ____ City __________________________

State ________ Zip __________ Phone (Primary) ______________ Phone (Alternate) ______________

Race: __________________ Ethnicity: ________________ Preferred Language: ____________________

RESPONSIBLE PARTY

Marital Status of Parents: ☐ Married ☐ Divorced or Divorce Pending ☐ Single (never married)

Mother's name ______________________________ Father's name ______________________________

Responsible party

Name ____________________________ Date of Birth_______________ SS # ____________________

Contact E-Mail address_________________________________ Cell Phone ( ) __________________

Home Address (if different from patient) ____

City ____________________ State ________ Zip _________ Home phone ( ) ________________

Employer _______________________________________ Work phone ( ) __________________

INSURANCE

Primary Insurance _______________________________________ Effective Date ________________

Full Name of Insured _______________________ Date of Birth ____________ SS# __________________

Relationship to Patient ______________Policy/ID # ____________________ Group# ________________

Secondary Insurance ______________________________________ Effective Date ________________

Full Name of Insured _______________________ Date of Birth ____________ SS# __________________

Relationship to Patient ______________Policy/ID # ____________________ Group# ________________

IN CASE OF EMERGENCY

Name _________________________Relationship _______________ Phone # __________________

Responsible Party Statement: I understand that payment of all medical care is due at time of service. The patient, parent of and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize Zaheer Pediatric Associates, S.C. and First Care Family Clinic S.C. to furnish information to insurance carriers concerning my medical or my child's medical treatments and I authorize payment directly to Zaheer Pediatric Associates and/or First Care Family Clinic.

Consent for Treatment: I authorize Zaheer Pediatric Associates, S.C. and First Care Family Clinic, S.C. to administer diagnostic and therapeutic tests, take photographs for medical/therapeutic purposes, and perform such procedures and render treatments as my be deemed necessary, acknowledging that no guarantees were made to me as to the diagnosis or results of treatment or examination.

Signature ____ Date ____________________

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Pediatric – Patient Questionnaire

Patient's Name ____ Address____

Completed By _____________________________________ Relationship _______________________Date ________________________

Reason for today's visit ____ Previous medical care Dr __________________________

Pregnancy & Birth

Mother's age at pregnancy_________ Was baby ☐ early ☐ late ☐ on time

Gestational age: ________ weeks. Hospital of Birth: _______________

Any illness during pregnancy ☐ yes ☐ no

Medications during pregnancy ☐ yes ☐ no

During pregnancy ☐ smoking ☐ alcohol ☐ street drugs

Type of delivery________________ Any complications?______________

Birth weight _____________________ Length ______________________

Problems with baby at birth? ☐ Breathing ☐ Jaundice ☐ Other(describe below)

Other____

Problems soon after either in hospital nursery or at home____________

List Medical History

Allergic reactions to: (Check the ones the apply to the patient)

☐ Medicine ☐ Food ☐ Animals ☐ Insect Bites

Any medications taken on a regular basis? (Exclude vitamins)

____

Are immunizations up to date ☐ yes ☐ no Do you have a record ☐ yes ☐ no

Hospitalizations (when, where, why?) ______________________________

____

Past Surgeries? ____

Serious injuries (when, where?) _________________________________

Past Medical History

☐ Red Measles ☐ Mumps ☐ Chicken Pox
☐ Rheumatic Fever ☐ Scarlet Fever ☐ Whooping Cough
☐ Asthma/Wheezing ☐ Eczema/Hives ☐ Seizures
☐ Anemia ☐ Hepatitis ☐ Bleeding Tendency
☐ Blood Transfusions ☐ German (3 day) Measles

Recurrent infections (3 or more): ☐ Ear ☐ Throat

Problems with: ☐ Hearing ☐ Vision

Other: ____

Feeding & Nutrition

Food Allergies ________________ Appetite usually good? ☐ yes ☐ no

Colic or feeding problems during first 3 months? ☐ yes ☐ no

Breast fed? ☐ yes ☐ no Number of months _________________

Formula? ☐ yes ☐ no Current brand_____________________

Vitamins? ☐ yes ☐ no Brand?_____________ Fluoride? ☐ yes ☐ no

Special diet?____

Family Medical History

List all blood relatives of your child who have had the following problems – Use abbreviations. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MGM) Mother's Mother, (MGF) Mother's Father, (PGM) Father's Mother, (PGF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood Disorder _____________ Epilepsy/Seizures ___________

Asthma __________________________ Heart Disease ______________

Mental Retardation _______________ High Blood Pressure ________

Drug Problems ___________________ Cholesterol Problem _________

Alcoholism ______________________ Migraine __________________

Cancer _________________________ Sudden Infant Death ________

AIDS ___________________________ Birth Defects ______________

Cystic Fibrosis __________________ Early Deafness _____________

Muscular Dystrophy ______________ Diabetes __________________

Tuberculosis _____________________ Arthritis __________________

Thyroid _________________________ Other ____________________

Development & Behavior (Age at which child:)

Sat Alone ________ Walked _________ Used Sentences ___________

Toilet Trained ____________ Bicycled ___________________________

Development compared to other children? _________________________

Grade In school _______________ Problems in school? ☐ yes ☐ no

Learning problems? ☐ yes ☐ no Behavior problem? ☐ yes ☐ no

Bad habits? __________________ Bedwetting? ☐ yes ☐ no

Nail Biting? ☐ yes ☐ no Sleeping? ☐ yes ☐ no

Hobbies – sports – social activities? ____________________________

Use of street or illegal drugs? ☐ yes ☐ no ____________________

Family Profile

Parents: ☐ Married ☐ Separated ☐ Divorced

Mother's age? _______ Highest school grade? ______ Health? _______

Father's age? _______ Highest school grade? ______ Health? _______

Any smokers at home? ☐ yes ☐ no

Any pets at home? (What kind)______________________________

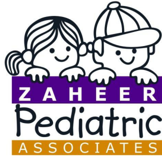
____

Child attend daycare/school? ☐ yes ☐ no

(List child's brothers and sisters and their age)

____

____



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Notice of Privacy Practices

This notice describes how Zaheer Pediatric Associates (ZPA) and First Care Family Clinic (FCFC) patient health information may be used and disclosed, and how to access patient health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ZPA commitment to patient privacy

ZPA and FCFC is dedicated to maintaining the privacy and confidentiality of all patient health information as required by law. This notice provides details to assist with patient understanding of these requirements.

Use and disclosure of health information in certain special circumstances

The following circumstances may require disclosure of health information:

1. Public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to patient health and safety or the health and safety of the public. Disclosures will be made only to a person or organization able to help prevent the threat.
5. For members of U.S. or foreign military forces (including veterans) if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if for inmates and those under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

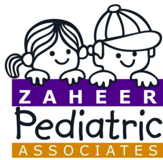
Rights regarding health information

1. Patients can request that ZPA and FCFC communicate health and related issues in a particular manner or at a certain location. For instance, patients may ask that ZPA and FCFC contact them at home, rather than work. ZPA and FCFC will accommodate reasonable requests.
2. Patients can request a restriction in ZPA's and FCFC's use or disclosure of health information for treatment, payment, or health care operations. Patients have the right to request that providers restrict disclosure of health information to only certain individuals involved in patient care or the payment for care, such as family members and friends. ZPA and FCFC is not required to agree to these requests, however, if agreed to, is bound by the agreement except when otherwise required by law, in emergencies, or when the information is necessary for treatment.
3. Patients have the right to inspect and obtain a copy of the health information that may be used to make decisions, including patient medical records and billing records, but not including psychotherapy notes. Requests must be submitted in writing to Zaheer Pediatric Associates or First Care Family Clinic.
4. Patients may ask ZPA and FCFC to amend health information if it is incorrect or incomplete. To request an amendment, requests must be made in writing and submitted to Zaheer Pediatric Associates or First Care Family Clinic.
5. Right to a copy of this notice. Patients are entitled to receive a copy of this Notice of Privacy Practices. ZPA and FCFC will provide a copy of this notice at any time to anyone who asks an employee at the front desk.
6. Right to file a complaint. If patients believe their privacy rights have been violated, they may file a complaint with ZPA and FCFC or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact ZPA and FCFC Office Manager. Complaints must be submitted in writing. Patients cannot be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. ZPA and FCFCwill obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Any questions regarding this notice or our health information privacy policies should be directed to Zaheer Pediatric Associates and First Care Family Clinic.

My signature below represents that I have read and understand this Notice of Privacy Practices.

____________________________	________________________________	________________
Patient's Printed Name	Patient, Parent, or Guardian Signature	Date



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Office Policies

NO SHOWS: If a patient misses 3 appointments without notifying our office at least 1 hour before the scheduled appointment, that patient will be dismissed from our practice.

APPOINTMENTS: You are expected to arrive promptly for you appointment. However, if you do arrive late, you will be given an additional 15 minutes from your scheduled appointment time to arrive for your appointment. If you arrive more than 15 minutes late, you will be given 2 choices.

- You may be seen after the other scheduled patients or in the next available time slot in the case of a cancellation or no show.
- You may reschedule your appointment for a different date.

Any arrivals more than 30 minutes late will be rescheduled. If you call us well before your appointment time, we will make every effort to accommodate your needs.

Please call 1 day in advance if you will be unable to make your scheduled appointment. This will avoid becoming involved in the dismissal process.

We do understand that unexpected situations may occur that could conflict with an appointment. However, we do expect some notice of cancellations. We strive to meet all of our patient's needs. We hope that these policies will work to the advantage of our patients as well as our practice. We appreciate your cooperation.

CO-PAYS: It is our policy to collect your insurance co-pay at every appointment. This simplifies the office process and ensures the financial obligation is met at the time of service. Payment is due at time of service and it will be your responsibility or of the person bringing your child/children to the appointment.

CO-INSURANCE/DEDUCTIBLES: Every effort is made to fairly estimate the co-insurance of deductible owed based on the nature of the visit.

MEDICAID: If you have Illinois Medicaid as a primary or secondary insurance and are enrolled in Illinois Health Connect, you must have one of our providers selected as a PCP. If you do not, we will not bill Illinois Medicaid and you will be responsible for any amount owed.

INSURANCE DENIALS: If we get claims denied from your insurance company because they are waiting for information from the member; those charges will automatically be placed as patient responsibility. If not resolved in a timely manner this may result in additional fees including; collection fees and late fees.

BILLING: As a courtesy, Zaheer Pediatric Associates bills your health insurance provider on your behalf.
ID Cards: It is critical that the most current insurance ID card is brought to every appointment. We must have the correct information at the time of service.
Auto: We may bill auto insurance for visits and medical care related to auto accident if all required information is provided at time of service. However, payment may be required in full if all required information is not provided.
Combined visits: If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.

ADMINISTRATIVE FEES: Zaheer Pediatric Associates may charge fees for the following administrative tasks:
Copies of medical records (see "Medical Record Copy Policy" for fee amounts)
FMLA paperwork ……………………………………………………..……………………..…..…..$15.00
Special request physician letters ………………………………………………….…..…..……$10.00
Returned check fee (insufficient funds)……………………………………..……………..…....$25.00
Monthly Late fee of 1.5% on all balances after 90 days past due.
Collection fee of 30% of the total owed when sent to collection, all attorney fees, and court costs.
Patients sent to collections will automatically be dismissed from the practice.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

____ Signature of Patient/personal representative

_____________________________________ Relationship to patient

____ Print patient's name (if different from above)

Date: ________________________________