Sierra Family Care Child History Form (Ages 0-17)

Name:____________________________ Age:______ DOB:_______ Today's Date:___________

Immunizations:
When was your last Tetanus shot:_______________
When was your last immunization:_______________
What kind of immunization was it:_______________
Circle any or all you have had:
DaPT #1, 2, 3, 4, 5 OPV #1, 2, 3, 4, 5
MMR #1, 2 Hib Hep B #1, 2, 3
When was your last Tb test:_________________

Birth History:
How many weeks/months was your mother pregnant with you?_______________________________
Any pregnancy complications? (Circle)
Swelling / Hi Blood Pressure / Fevers / Other_____
How long was your mother in labor? ____________
How were you born? (Circle)
Vaginal Delivery / C-Section
Birth Weight_________ Birth Length__________
How long did you stay in the hospital? __________
Did you need: (Circle)
ICU Care / Oxygen / Transfusions / Medicine / Other________________

Past History:
Have you had: (write the year)

Jaundice______	Convulsions__________
Pertussis______	Whooping Cough______
Mumps_______	Chicken Pox_________
Measles______	Diphtheria___________
Rubella_______	Scarlet Fever_________
Tonsillitis______	Rheumatic Fever_______
Otitis________	Hay Fever___________
Bronchitis_____	Allergies____________

Family History: (List blood-relatives only)

Seizures______	Mental Illness_________
Allergies_______	Birth Defects_________
Asthma_______	Tuberculosis__________
Ulcers________	Liver Disease_________
Colitis________	Kidney Disease_______
Goiter________	Lung Disease_________
Arthritis______	Hi Blood Press________
Diabetes______	Heart Attack__________
Retardation_____	Cancer(**type**)_________

How many brothers____ Ages_____________
How many sisters____ Ages_____________
Mother's Age_____ Father's Age_____

Surgeries/Hospitalizations/Illness/Injury:

Year	Type
____	______________________________
____	______________________________
____	______________________________
____	______________________________
____	______________________________
____	______________________________
____	______________________________

Current Medications: ____________________
____
____
____

Medication/Food/Environment Allergies:
(List reactions too)
____
____

General Health: (Circle) Good / Fair / Poor

Review of Systems: (Circle if current)
Skin: eruptions, bleeding, bruising, moles, eczema, hives
Lymph Nodes: enlargement, pain, drainage
Bones/Joints/Muscles: pain, cramps, swell
Blood: anemia, bleeding problems
Glands: goiter, growth problems, hunger, thirst, intolerance to heat/cold
Head: aches, fainting, convulsions, injury
Eyes: glasses, double vision
Nose: runny, nose bleeds, snoring
Mouth: pain, tooth trouble, sore throat
Neck: pain, swelling, decreased motion,
Breasts: pain, swelling, discharge, lumps
Lungs: wheezing, pain, cough, SOB
Heart: abnormal beats, pain, turn blue
GI: appetite, large weight gain/loss, jaundice, vomiting, bowel problems
GU: UTI, stones, blood in urine, discharge, bed wetting
CNS: difficulties with smell, taste, tough, speech, chewing, hearing, balance, paralysis, sleep coordination, hallucinations, walking, swelling
Other:______________________________
____
____

Sierra Family Care Patient Information Sheet

Mr./Mrs./Ms./Miss (Circle One) **Male or Female (Circle one)**

Patient's Name:____ **Suffix:**_______

Age:_____ **Date of Birth:**___________ **Social Security Number:**____________________

Cell#:__________________ **Home#:**_________________ **Work#:**_________________

Email:____

Address/City/State/Zip:____

Mailing Address:____

Preferred Pharmacy/Zip Code:____

Preferred Language:_______________________ **Ethnicity:**________________________

Emergency Contact: **Name:**_______________________ **Relation:**___________________

Phone#:________________________ **Phone Type: Cell/Home/Work (Circle One)**

Address:____

If patient is a minor, list other parent/guardian name/phone#:______________________

Financial Responsibility: **Relation to patient:**___________________________________

Name:____

Employer:__________________________ **Occupation:**_________________________

Address:____

Date of Birth:_________ **Gender:**_________ **Social Security Number:**_______________

Primary Phone:_____________________ **Secondary Phone:**_______________________

I consent to treatment necessary for the care of the patient named above.
I allow fax and electronic transmittal of my records, if necessary.
I understand that I will receive up to 3 statements for any unpaid services and, if still unpaid, then my account will be sent to collections.
I understand that payment is due at the time of service.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment.
I further authorize and request that my insurance payments be directly made to Sierra Family Care.
I understand that this office uses an electronic medical record.
I have read and fully understand the above consent for treatment, financial responsibility, and release of medical information and insurance authorization.

Date:_____________ **Signature:**____

(rev. 12/19)

Sierra Family Care Payment Policy

Thank you for choosing us as your primary care provider. We are committed to the provision of superior and personalized care.

This payment policy outlines our expectation of payment for services we render. **It is required that you read and sign this agreement in order to be a patient of Sierra Family Care.**

1. **No Insurance:** Refer to the "Uninsured/Cash Patient Affidavit."
2. **Insurance (Participating Provider):** We participate with numerous insurance plans. That means we will bill those companies and accept the contracted rate for care. It is your responsibility to know the limits and coverage of your insurance. Please contact your insurance with any questions you may have in regard to contracted providers.
3. **Insurance (Non-Participating Provider):** If you have an insurance with an out-of-network benefit, then Sierra Family Care may still be able to provide services to you. Be aware that in this situation, your co-payment and deductible will likely be higher. If you have further questions, then please contact your insurance company.
4. **Co-Payment and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with the insurance company. These fees cannot be waived.
5. **Non-Covered Services:** Please be aware that some, and perhaps all, of the services you receive may be considered by your insurance company or Medicare to be "non-covered" services or even considered to be "not-reasonable or medically necessary" as outlined by their own standards for coverage of services. Be assured that we only provide services in agreement with you and that we feel are indeed necessary for your physical or mental well-being. **As such, any services deemed not coverable by your insurance will be your responsibility to pay for.**

   Examples:
   1. **Vaccines and Tests:** Some vaccines and screening tests at certain ages, although advised, may not be considered covered services by your insurance plan.
   2. **Timing:** Payers often deny certain services because they perceive the service as medically unnecessary if it is performed sooner than expected by the payer.
   3. **File/Form Fees:** Expenses incurred for the processing of patient, pharmacy, governmental, or insurance requests that require medical record review and documentation with or without a change in care plan are not billable to payers.

   File/Form Fees range from $3 per event that requires medical record review and documentation between office visits (including prescription requests) to $25 or more for the completion of a wide variety of special forms related to one's state of health, disability, retirement, school, travel, and specialized examination and documentation beyond or in addition to that which is usually covered at an office visit for your healthcare.

6. **How to Avoid Fees:** You do not like paying them and we do not like charging them. The vast majority of file fees are for prescription refill requests made between office visits. Your participation in your care will result in avoiding these fees if you would simply **bring all of your medications to every visit** and make sure you have enough refills to get you through to your next scheduled office visit.
7. **Claims Submission: Synapse** is our contracted billing service. We will submit your claim via Synapse and assist you in getting your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company. We will also abide by any agreement that we may have in place with your insurance company.
8. **Coverage Changes:** If your insurance changes, then please notify us before your next visit so we can make appropriate changes to help you maintain your benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
9. **Non-Payment:** If your account is over 90 days past due, then you will receive a letter stating that you have 20 days to pay your account in full. Please immediately contact our office manager if you need to arrange partial payments. **Please be aware that if a balance remains unpaid, then we will refer your account to a collection agency** and you, and/or your immediate family members for whom you are the guarantor, may be discharged from the practice. If this does occur, you will be notified by mail that you have 30 days to find alternative medical care after which time we will no longer provide any services to you and/or your covered family members.

The policies outlined above are designed to allow us to work together more efficiently for the benefit of our patients. Thank you for your understanding in this matter.

I have read and understand the payment policy and agree to abide by this payment policy.

Name: (print) ______________________________

Signature: ______________________________

Date: ______________________________

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The federal government has published regulations designed to protect the privacy of my health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other healthcare providers, and health plans.

I, ______________________, have reviewed a copy of the Notice of Privacy Practices from Sierra Family Care.

____
Signature

____
Date Signed

(rev. 12/19)