Parkway PEDIATRICS

Patients Demographic Information Sheet

Patient/Child Information

Child's Name:_____ ☐ Male ☐ Female Date of Birth:_____
Child's SSN:_____
Child's Ethnicity (circle): American Indian / Hispanic or Latino /Asian / Black or African American / Caucasian / Other

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Child resides with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other

Mother's Name: _____ Date of Birth:_____
Home Address: _____ City, State, Zip_____
Home Phone: _____ Cell Phone:_____ Work Phone:_____
Email Address:_____

*Father's Name:*_____ Date of Birth: _____
Home Address:_____City, State, Zip_____
Home Phone: _____ Cell Phone:_____Work Phone:_____
Email Address:_____

Messages *(unless requested otherwise, we only leave our name/phone and general message regarding appointments)*
OK to leave a detailed message on provided numbers? ☐ YES ☐ NO OK to leave appointment reminders/confirmations? ☐ YES ☐ NO

Insurance Information (ALL Private AND Medicaid insurance policies MUST be reported)

Primary Insurance: _____
Member ID: _____Group #:_____
Secondary Insurance: _____
Member ID:_____Group#:_____
Subscriber Name: _____ Relationship to patient:_____
Subscriber Social Security: _____ Subscriber DOB: _____

Pharmacy Information
Name & Location: _____
Phone: _____

Guarantor Payment Responsibilities: *I hereby authorize Parkway Pediatrics LLC to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. Parkway Pediatrics LLC is required to collect my copay/deductible charges at the time of service as this will be reported to my insurance company. My charges maybe adjusted if my insurance is not "In-Network". It is my responsibility to know if my insurance is "In-Network" with Parkway Pediatrics LLC. All rejections for claims with insurance providers will be mine/patient's responsible party's responsibility of full payment. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Parkway Pediatrics LLC; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.*

By signing below, I certify that I have read and understand the notice above, which explains how my medical information will be used and disclosed and the Guarantor Payment Responsibilities.

_____ _____
Parent/Guardian Signature Date

Parkway Pediatrics LLC

New Born History Questionnaire

Patient Name:_____ **Date:**_____

Pregnancy/Birth History:

1. Were there any complications or medications taken during the pregnancy? _____
2. OBGYN: _____ Pediatrician seen at hospital:_____
3. Was there any use of tobacco, alcohol, or illegal drugs during pregnancy? _____
4. What hospital was baby delivered at?_____ Gestational Age? _____Weeks
5. Type of delivery? ☐ **Vaginal Delivery** ☐ **C-Section** ☐ **Induction** Was baby in breech position? ☐ **Yes** ☐ **No**
6. What was the birth weight? _____ Height? _____
7. Any complications during delivery or nursery stay? ☐ **Yes** ☐ **No** If yes, explain_____
8. Any abnormalities with Newborn/ Hearing screen or Bilirubin Levels? ☐ **Yes** ☐ **No** Was a copy provided to us? ☐ **Yes** ☐ **No**

New Born Care:

1. Nutrition: ☐ **Formula Fed** ☐ **Breast Fed** ☐ **Both** If Formula, Which brand/type?_____
2. Feeding amount? _____ **oz.** frequency (how often): _____
3. Does baby spit up? ☐ **Yes** ☐ **No** If yes, amount? _____ Frequency?_____
4. Water source for mixing formula? ☐ **Nursery Water** ☐ **Bottle Water** ☐ **Tap Water** ☐ **Other**
5. If baby boy- is he circumcised? ☐ **Yes** ☐ **No** If yes, who did the procedure?_____
6. Is baby going to receive all recommended immunizations? ☐ **Yes** ☐ **No**
7. Any plans for daycare or sitters? _____
8. Any concerns or questions? _____

_____

Family medical history:

1. Any significant illnesses in mother/father/ sibling?_____
2. Are patient's grandparents : ☐ **Living** ☐ **Deceased** ☐ **Both**
   a. Cause of death / any serious health concerns?_____
3. Mother's height? _____ Fathers height? _____
4. Are any family members very short? ☐ **Yes** ☐ **No** Very tall? ☐ **Yes** ☐ **No**
   Underweight? ☐ **Yes** ☐ **No** Overweight? ☐ **Yes** ☐ **No**
5. Are there any extended family members with genetic disorders? (sickle cell, cystic fibrosis, hemophilia) ☐ **Yes** ☐ **No**
   Please List:_____

Social History:

1. Patient lives in : ☐ **House** ☐ **Apartment** ☐ **Trailer** ☐ **Farmhouse**
2. Who else lives in home? _____
   a. Please list the ages of any siblings living in home: _____
3. Are there any smokers in the family? ☐ **Yes** ☐ **No** Do they smoke in the home? ☐ **Yes** ☐ **No**
4. Are there any pets living inside the home? ☐ **Yes** ☐ **No** Outside? ☐ **Yes** ☐ **No**
5. Water source for the home? ☐ **Well Water** ☐ **City Water** ☐ **Other**
6. Lead source in home? (Ex. Old paint, highway or factory nearby) _____

Parkway Pediatrics LLC

Authorization for Release of Medical Records

Patient's Name: _____ **DOB:** _____

This letter will authorize this office to provide a copy, summary, or narrative of my medical records as indicated by the check marks below or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete Record

_____Records of care from _____ to _____ only

_____ Records of Care concerning the following conditions: _____

_____ Other: Specify: _____

HIV/AIDS/other STDs: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or other causative agent of AIDS, with the rest of my medical records. **Initial** **Date**

Previous Doctor: _____ **Address:** _____

Phone: _____ **Fax:** _____

To the Following Person(s):

Dr. Kelli M. Cocke, M.D.
Parkway Pediatrics, LLC
6800 Ambassador Caffery Parkway
Broussard, Louisiana 70518
337-330-4525 (phone) / 337-330-4526 (fax)

The reason or purpose for this release of information is:

_____ Physician Change

_____ Second Opinion

_____Other: _____

Signed: _____ **Date:**_____
(Patient or Person legally authorized to consent on patient's behalf)

_____ _____ _____

Relationship to patient **Witness** **Date**

****Please Fax or Mail the medical records/immunization records promptly, Thank you for your cooperation.***

Parkway Pediatrics, LLC- Dr. Kelli Cocke, M.D.

Parkway Pediatrics, LLC. is a physician owned and operated facility.

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information. Our Full Privacy Policy Form/Patient Policy and Insurance/Billing Policy can be found on our website at pkwypeds.com, posted in our office lobby or you can request a copy.

Consent Related to Privacy Notice:

I have reviewed the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change at any time. I may obtain these revised notices by contacting the practice by phone or in person. I understand I have the right to inspect, copy, receive confidential communications from Parkway Pediatrics, LLC by alternative means, have the physician amend and request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but Parkway Pediatrics, LLC is not required to agree to my restrictions.

Consent for Care:

I, with my signature, authorize Parkway Pediatrics, LLC, Dr. Kelli Cocke M.D. and any employee working under the direction of the physician, to provide medical care for me, or the patient for which I am the legal guardian of. Medical care, services and supplies related to myself/patients health, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, immunization/vaccine administration, assessment or review of physical or mental health of the body and the dispensing of prescriptions, samples, devices/equipment or other items required. This consent may include contact and discussion with other health care professionals for care and treatment.

Patient Policy:

I have reviewed the Patient Policy as part of this registration process. I understand that patients must be present at the time of appointment. I agree to cancel all appointments within a reasonable time, unless due to an emergency. I understand that 3 "no-shows" or 6 "last minute cancellations" for appointments will result in dismissal from our clinic. I also understand and agree that arrival of more the 20 minutes late for my/patients appointment will be marked as a "no-show" or "last minute cancellation" and I will be asked to reschedule. All "no shows" for ADD/ADHD appointments will result in denial of ADHD medicine refills until patient is seen.

Financial Policy:

I, the patient/responsible party assume responsibility to ensure that the financial obligation is fulfilled for the health care services received. I also authorize this practice to furnish information to the billing office in connection to Parkway Pediatrics,LLC and identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice.

*I understand that I am responsible for all balances, co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment, co-insurance or deductible charge I am expected to make that payment when checking in for my appointment. I also understand I am required to pay 20% of any balance over $300 before I can be seen. I understand that if my balance is below $300, I/patient will still be seen, however, a payment or payment plan must be made prior to being seen.

*I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Parkway Pediatrics, LLC. is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

*I understand that a wellness visit consists of an exam and any vaccines that are required by age. I agree that any additional concerns will constitute a "problem" visit in addition to the wellness visit and result in a charge from our office or the patients insurance. If you do not advise the front office staff and do not pay the co-pay, co-insurance, or deductible charge you/patient will be billed.

Authorization to Communicate: I understand that Parkway Pediatrics, LLC utilizes various communication methods including voice calls, email and fax for the purposes of sharing clinical/ medical results, scheduling appointments, sending appointment reminders and communicating/ discussing financial responsibilities. By signing this form, I am granting permission to Parkway Pediatrics, LLC to utilize all phone numbers/addresses that I have supplied to contact me regarding this current visit and any future visits for the above stated purposes. I further understand that I have a right to revoke this authorization at any time by communicating this request to Parkway Pediatrics, LLC.

Release of Information: I authorize Parkway Pediatrics, LLC to release medical or other information to my primary care or referring physicians, the insurance companies, the Louisiana Department of Health and Hospitals (Medicaid and SSI), or any third party acting on my behalf or Parkway Pediatrics, LLC's behalf which is needed for benefits to be paid under my insurance or other contracts applicable to claim for treatment. I hereby indemnify and release Parkway Pediatrics, LLC from any and all responsibility relative to the release of such information. I understand that Parkway Pediatrics, LLC will make any disclosures that are required by law to meet mandatory reporting requirements. I hereby idemnify and release Parkway Pediatrics, LLC from any and all responsibility relative to the release of such information.

I have read and understand **ALL** of the above Policies/Consents and agree to accept full responsibility as described above.

_____

Patient Name

_____ _____

Patient Guardian Signature Date

Kelli M. Cocke, M.D.

6800 Ambassador Caffery
Broussard, LA 70518
337-330-4525 Office
337-330-4526 Fax
pkwypeds@gmail.com

New policy- effective 1/16/2019

To all newborn baby mothers:

Please call Medicaid or your private insurance company as soon as possible to start the application process. Once you have picked your plan and received your insurance cards be sure to give us a copy for the chart. If this has not been done by the time the baby is 1 month old it can be harder to get the baby on insurance. If the baby does not have active insurance by his/her 2 month wellness visit then we will need the balance paid in full before the baby can be seen. This balance will include hospital charges and office visit charges.

**We do accept all Medicaid plans which include: United Healthcare Community Plan (UHCP), Aetna Better Health of LA, AmeriHealth Caritas of LA, Louisiana Healthcare Connections, and Healthy Blue of LA. We accept all private insurances.

Thank you for your cooperation

Parkway Pediatrics staff

Patient name:_____

Signature:_____ Date:_____