

Allyson Van Steenbergen M.D. Angel Zieba M.D. Barbara Kissam M.D.
Heather D. Owens M.D. V. Susan Bradford M.D.

**MERIDIAN PEDIATRICS
PATIENT REGISTRATION FORM**

(Please print)

Today's date: _____ Physician: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____
Zip Code: _____ Phone: _____ Male or Female: _____

INSURANCE/ GUARANTOR INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ DOB: _____
Social Security Number: _____

Address: (If different from above) _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Email: _____

(We will use your email address only for appointment confirmation)

Employer: _____ Employer Phone Number: _____

INSURANCE CARRIER:

(Without this information we are unable to bill your insurance.)

Primary Insurance Company: _____

Subscriber: _____ DOB: _____ Social Security Number: _____

Insurance Address: _____ City: _____ State: _____

Phone: _____ Policy #: _____

Group #: _____ Relationship to patient: _____

Copay or Deductible amount: _____



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HIPAA AUTHORIZATION FORM

Patient Authorization for use and Disclosure of Protected Health Information.

By signing, I authorize Meridian Pediatrics to use and/ or disclose certain protected health information about me to insurance carriers, other physicians or agencies to whom a referral for care may be made.

This authorization permits Meridian Pediatrics to use and/ or disclose the following individually identifiable health information about me including but not limited to dates of services, types of services, and diagnosis rendered.

I acknowledge that by signing, I authorize Meridian Pediatrics to receive payment from a third party (insurance) in exchange for using or disclosing the Protected Health Information.

I do not have to sign this authorization in order to receive treatment from Meridian Pediatrics. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to the privacy officer at Meridian Pediatrics.

I also acknowledge that by signing, I authorize Meridian Pediatrics to leave Protected Health Information on a secured voicemail, i.e. Lab results and appointment confirmation calls.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's name

Date

Secured phone number/voicemail for Lab results & Appointment Confirmation calls



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FAMILY HISTORY

Have any family members had any of the following?

	YES	NO	WHO?
Deafness			
Nasal allergies			
Asthma			
Tuberculosis			
Heart Disease (before 50 years old)			
High Blood pressure (before 50 years old)			
High cholesterol			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Diabetes (before 50 years old)			
Bed-wetting (after age of 10)			
Epilepsy/ Convulsions			
Alcohol abuse			
Drug abuse			
Mental Illness			
Mental retardation			
Immune problems, HIV Aids			
Additional family history:			
PATIENT PAST HISTORY: Has your child ever had:			
Chickenpox			
Frequent ear infections			
Nasal Allergies			
Problems with eyes/ vision			
Asthma, bronchiolitis			
Pneumonia			
Any heart problem or heart murmur			
Anemia or bleeding problem			
Blood transfusion			
Frequent Abdominal Pain			
Constipation requiring doctor's visit			
Bladder/ Kidney infection			
Bed-wetting after age of 5			
Has she started her menstrual periods			
Chronic or recurrent skin problems			
Frequent headaches			
Seizures or neurological problems			
Diabetes/thyroid problem			
Use of alcohol or drugs			
Any other significant problems			



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INITIAL HISTORY QUESTIONNAIRE

NAME: _____

Date of Birth: _____ Age: _____

Form completed by: _____ Date: _____

Household Information:

Name	Relation to child	Birth Date	Health Problems

Are there siblings not listed? If so give names and where they live. If one or both parents are not living in the home, how often does he/she see that parent? _____

Birth History

Birth weight _____ Vaginal or Caesarean Section? (please circle) If Caesarean, why? _____

Was your baby born term or early? If early, why? _____

Any illness or problems in the pregnancy? Yes No How many weeks gestation? _____

During pregnancy did mother smoke, drink alcohol, or use illicit drugs? Yes No

Was mother on any medications during pregnancy? Yes No

Did your baby have any problems right after birth? Yes No If so, what were they? _____

Was initial feeding Breast or Formula?

Did your baby go home with mother from the hospital? Yes No

General

Do you consider your child to be in good health? Yes No Explain: _____

Does your child have any illness or medical condition? Yes No Explain: _____

Has your child had any serious injuries or accidents? Yes No Explain: _____

Has your child had any surgeries? Yes No Explain: _____

Has your child ever been hospitalized? Yes No Explain: _____

Is your child allergic to any medications? Yes No Explain: _____

Is your child allergic to any foods? Yes No Explain: _____

Is your child on any chronic medications? Yes No Explain: _____

Development

Are you concerned about your child's physical development? Yes No Explain: _____

Are you concerned about your child's mental or emotional development? Yes No Explain: _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she repeated or failed a grade in school? Yes No Explain: _____

How is his/her academic performance? _____

Is he/she in a special/resource class? Yes No Explain: _____



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PAYMENT , INSURANCE AND CLINIC POLICY

***WE APPRECIATE THE OPPORTUNITY OF SERVING YOU
&
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE***

PAYMENT POLICY: _____ Initials

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 30 days will be charged 1.5% per month or 18% per annum. In the event that any balance due is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs exceed 20% of said unpaid balance, including a reasonable attorney's fee.

INSURANCE POLICY: _____ Initials

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will be happy to submit to most carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by your Insurance carrier. Please understand that as a third party, we cannot be involved in prolonged insurance negotiations; this is your responsibility.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS: _____ Initials

I authorize the Doctor to release any medical information including, diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information may be used for the following purposes: diagnostic, insurance, & legal purpose. I further understand that any persons receiving these medical records will not release any of the medical information obtained by this authorization to another person or organization without a further authorization signed by me for release of information.

LATE POLICY: _____ Initials

In order for your physician to be able to provide the best care possible it is important to be on time for your appointment, therefore: **If you are more than 10 minutes late for your appointment, please be prepared to reschedule your appointment.**

IMMUNIZATION RECORDS: _____ Initials

Please bring your immunization card with you to every scheduled well child exam.

PRESCRIPTION REFILLS: _____ Initials

Please allow 48 hours for all prescription refills and utilize our prescription refill line.

I have read the above and accept financial responsibility in full for this account:

Signed: _____

Date: _____

Printed name: _____



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name: _____ **Date of Birth** _____ **SS#** _____
(Please Print)

I authorize Meridian Pediatrics to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

From: _____
Physician/Institution that presently has data

Street Address

City State Zip Phone

To: _____
Physician/Institution requesting data

Street Address

City State Zip Phone

Release the following Protected Health Information:

All Records Chart Notes X-Rays Labs Substance Abuse Info Mental Health HIV
 Other (please specify): _____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information) _____

The Protected Health Information is being used or disclosed for the following purpose: (If the patient is requesting the release, this may state, "at patient request") _____

(List specific purposes the Protected Health Information will be utilized)

This authorization is in full force and effect until _____ or until _____
(Date) (List specific Event)

I understand that I have the right to revoke this authorization in writing by sending notification to the address stamped below:

I understand that when I revoke this authorization, it is not effective to the extent that the Clinic has already relied on the use or disclosure of the Protected Health Information.

I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer e protected by federal or state law.

The Clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure,, unless the provision of health care is solely for the purpose of creating Protected health information to be used or disclosed.

I understand that I have a right to refuse to sign this authorization.

If you have any questions regarding this form, please contact the clinic manager.

(Signature of Patient or Patient Representative)

(Date)

(Printed Name of Patient or Patient Representative)

(State authority to act as authorized representative)

Name _____
DOB: _____



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MERIDIAN PEDIATRICS
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient ID #: _____

I hereby acknowledge that I have received a copy of Meridian Pediatric's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative	Date
Printed Name of Patient's Representative (if applicable)	Relationship to Patient (if applicable)
	<input type="checkbox"/> Parent or guardian of unemancipated minor
	<input type="checkbox"/> Court appointed guardian
	<input type="checkbox"/> Executor or administrator of decedent's estate
	<input type="checkbox"/> Power of Attorney

 FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,
 _____ but acknowledgment could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)



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MERIDIAN PEDIATRICS PATIENT PRIVACY NOTICE

OUR PLEDGE TO YOU

We understand that medical information about you is private and personal. We are committed to protecting it. Doctors and other staff make a record each time you visit our clinic. This notice applies to the records of your care at *Meridian Pediatrics*, whether created by your doctor or other staff.

We are required by law to:

- Keep medical information about you private
- Give you this notice describing our legal duties and privacy practices for medical information about you.
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND SHARE YOUR MEDICAL INFORMATION

This section of our notice tells how we may use medical information about you. IN all cases note covered by this notice, we will obtain a separate written permission from you before we use or share your medical information. You can later cancel your permission by notifying us in writing. We will protect medical information as much as we can under the law. Sometimes state law gives more protection to medical information than federal law. Sometimes federal laws give more protection than state law. In each case, we will apply the laws that protect medical information the most.

Treatment: We will use and share medical information about you for purposes of treatment.

Payment: We will use and share medical information about you so we can be paid for treating you.

Healthcare Operations: We will use and share medical information about you for the purpose of improving our healthcare operations.

Appointment Reminders: We may contact you with appointment reminders.

Treatment options and health-related benefits and services: We may contact you regarding possible treatment options, health-related benefits or services that you might want.

Public Health: We will report certain medication information for public health purposes.

Required by Law: We are sometimes required by law to report certain information.

Public Safety: We may, and sometimes have to share medical information about you in order to prevent or lessen a serious threat to the health or safety of a particular person or general public.

Coroners, Medical Examiners, and Funeral Directors: We may share medical information about deceased patients with coroners, medical examiners or funeral directors.

Organ and Tissue Donation: We may use or share medical information with organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: We may use or share medical information about you for national security purposes.

Judicial Proceedings: We may share medical information about you in response to court orders or subpoenas only when we have followed procedures required by law.

Law Enforcement Idaho: We may share medical information about you with police without your written permission.

Family Members and Other involved in your care: Unless you tell us otherwise, we may share medical information about you with family members or others you have named who help with your medical care.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

Requesting information about you: You can look at or get a copy of medical information about you.

Correcting Information about you: If you believe that information about you is wrong or missing, you can ask us in writing to amend the records. We do have the right to deny this request.

Obtaining a list of certain Disclosures of Information: You can ask in writing for a listing of every time we shared medical information about you, other than for treatment, payment, health care operations or when you have given us permission for the sharing. Your request must state the time period for the listing, which must be less than 6 years starting after April 14, 2003. The first request in a 12-month period is free. We will charge you for any additional requests for our cost of producing the list. We will give you an estimate of the cost when you request the additional list.

Restricting how we Use or Share Information about You: You can ask that medical information be given to you in a confidential manner. You must tell us in writing of the exact way or place for us to communicate with you.

DO YOU HAVE CONCERNS OR COMPLAINTS?

If you think your privacy rights may have been violated, you may contact our Chief Privacy Office below:

Cynthia Barinsky, Clinic Operations Manager
Meridian Pediatrics
3653 North Locust Grove
Meridian, ID 83646
208-338-5437 ext. 308