



HERITAGE
- FAMILY MEDICINE -

Child Demographics

All information is kept strictly confidential.

PATIENT FULL NAME: _____ DATE OF BIRTH ___/___/___
STREET: _____ CITY: _____ STATE _____ ZIP: _____
EMAIL: _____@_____ PARENT HOME PHONE: _____ CELL: _____ WORK: _____
SOCIAL SEC #: _____ PREFERRED PHARMACY: _____ TOWN: _____
HOW DID YOU HEAR ABOUT US? PERSON: _____ SIGN ONLINE DRIVE BY AD

FOR EMERGENCY

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____
PHONE: _____ CELL: _____ CITY: _____ STATE: _____

INSURANCE

RESPONSIBLE PERSON ON CARD: _____ THEIR DATE OF BIRTH ___/___/___
EMPLOYER NAME: _____ PHONE NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

It is very important to understand the following insurance terms:

Deductible: The amount you pay for covered health care services **before** your insurance plan starts to pay for your child. There may be a *family* deductible. (They pay *nothing* until you have paid this amount.)

Co-Insurance: The percentage of costs of a covered health care service you pay, (example 20%), **after** you've paid your deductible.

Co-Pay: A fixed amount (example \$30) you pay for a health care service **after** you've paid your deductible.

Before we can accurately charge your insurance, we need to know these numbers. Please take a moment to call your company (1-800 number on back of insurance card) and ask them about your responsibility for these three things.

Deductible: \$ _____ per year
Co-Pay: \$ _____ per visit
Co-Insurance: _____ % of charges

(No Blanks! We must have these numbers before continuing. Only put "Zero" if insurance says zero).

Special Cases:

Are you paying yourself for the visit? yes no
Will you submit bills to a health sharing account? yes no

Privacy



RELEASE OF INFORMATION

I would like Heritage Family Medicine to share my child's private medical information with the following people listed below. This may be a spouse, family member, or friend. I understand this will allow the staff at the clinic to communicate with my chosen representative(s) and pass on information to me, including, but not limited to appointments, results, diagnoses, labs, tests, and other important information. ****The person(s) listed under consent for medical care has my permission to bring my child in for medical services, including vaccination, sutures, minor surgery, or anything required for health.****

NAME	RELATIONSHIP	PHONE
Consent for Medical Care*		

In accordance with Alaska State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: 1. This authorization may include disclosure of information relating to alcohol, drugs, HIV or other health information. I specifically authorize release of such information to the person(s) indicated. 2. I have the right to revoke this authorization at any time by writing to the clinic. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. 5. Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law. I release and hold harmless Heritage Family Medicine, LLC. and members and employees thereof, from any and all consequences of this release.

PATIENT SIGNATURE: _____ **DATE:** ____/____/____

Payment Policy

Billing Practices:

Heritage Family Medicine contracts R&R Billing Service to handle all billing. Their offices are off site from the clinic. Because of this, only known co-pays or outstanding bills received in the mail are collected at the office. Charges from the day's visit will be sent promptly in the mail. For patients without health insurance, we require payment at the time of service. If you are a new patient and uninsured, we will collect a deposit of \$300 dollars cash or credit before your visit. Any refundable portion will be returned after your visit. In some cases, we may collect an amount less than the full charge for the visit and you will be billed accordingly. Overcharges will be refunded in a timely manner. If you need to make payment arrangements, please let us know. Any balance over 90 days will be charged a 20% service fee.

A Word about Insurance

Please understand that your health insurance policy is an arrangement between you and your insurance company. You have a separate relationship with our office, and are responsible for full payment of your account, regardless of the status of your insurance claim. Unfortunately, insurance companies are paying less each year, but our costs continue to rise. We cannot be expected to understand all the particulars of hundreds of plans, so please read your policy. As a service to you, we will file insurance claims for each of your insurance policies. You will need to furnish the clinic with all necessary information. If you are expecting payment from a car insurance policy, you will need to pay for your visits up front. We will reimburse you if, and when, the car insurance pays on the claim. *Note - Many insurance companies do not pay for certain physicals. Because of this, at the time of the visit, Heritage Family Medicine will collect \$50.00 for sports physicals and \$150.00 for DOT/CDL physicals. If your insurance policy covers them you may be entitled to a refund if you have met the requirements of your insurance company.

Fees for Services

Fees for medical services are based on the cost of procedures performed, the amount of professional skills involved, the amount of administration and record review required, and the amount of time-spent. Our office fees for professional services are determined in the same manner as those of other various physicians' offices throughout Alaska and the United States. Appropriate charges for the completion of various forms will apply. R&R Billing will be glad to speak with you about our fees at the number below. We will be happy to estimate your charges; however, due to the nature of diagnosing medical problems, it is difficult to be precise concerning total charges. If at any time you have questions about your charges, please let us know.

No Show Fee

Not showing up for an appointment with your child, or failing to call to cancel significantly affects our ability to provide flexible appointment times and same day appointments. Because we respect your time and we want you to respect ours, we have a "no-show" policy. There is a token administrative fee of **\$100 for each "no-show"**. Please call 24 hours in advance, if possible, to cancel an appointment and avoid any fees.

Payment Options

We accept cash, personal checks, Visa, and MasterCard. Payments can be made over the phone, through the mail, or in person. R&R Billing is happy to assist you with any questions and can be reached at 745-6440.

What if the account is not paid?

We want to be understanding and cooperative with everyone. Our staff will work with you in setting up payment arrangements if necessary. However, for those patients who do not fulfill their obligations after 90 days, it will be considered in everyone's best interest for those accounts to be referred to a collections agency. If a patient has been referred to a collection agency, future visits may be paid at the time of service with cash or credit while back debt is being paid.

Acceptance of Responsibility

"I understand that I am financially responsible for all charges whether or not paid by an insurance company. I know that it is my responsibility to notify Heritage Family Medicine of any changes to my account. This includes changes in insurance, address, telephone numbers, emergency contacts, etc."

Patient Name: _____ **Signature:** _____ **Date:** ___/___/___

Child Medical History

Pediatric Patients 0-16 years



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Child's Name: _____

Medication: _____ No Medications Taken

Drug Allergies: _____ No Known Drug Allergy

Past Medical History: (Please check any medical problems you've had and note active or inactive problems, or the year occurred or started).

<input type="checkbox"/> Acne	<input type="checkbox"/> ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Cancer/Type	<input type="checkbox"/> Depression
<input type="checkbox"/> Baby Circumcision	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Family/Congenital Dz	<input type="checkbox"/> Moles/Birthmark
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Valve	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Migraines
<input type="checkbox"/> Seizures	<input type="checkbox"/> Suicide Attempts	<input type="checkbox"/> Undescended Testicle	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Teen Girls Only:

Menstrual Periods Yes No (first day): ___/___/___ Any Pregnancies? Yes No

Sexually Active Sexually Yes No Any Sexually Transmitted Disease History? Yes No

Past Surgical History: (write the **date** next to the surgery)

Type of Surgery: _____ Date: _____ Type of Surgery: _____ Date: _____

Family History: If Living

If Deceased

Your child's:	Age	Major Health Problem	Age	Reason Died
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
Sister				

Social History:

Ethnicity: Prefer Not to Answer

White Black Asian Pacific Is N. American White Hispanic Black Hispanic

Occupation: Baby Daycare Pre-School Kindergarten School Student Working

Tobacco Use: Non-Smoking Home Smokers Outside Smokers Inside Home

Screen Time (TV, Tablets, Phones, Video Games, etc)

< 1 hour per day 1-2 hours per day 3-4 hours per day Many hours per day

Parent Reading Time (an older person reading to the child):

< 1 hour per day at least 1 hours per day

Independent Reading Time: (books, picture books, etc)

< 1 hour per day at least 1 hours per day 3-4 hours per day Many hours per day

Health Care Maintenance: Have you had the following tests done?

Exam:	Date:	Results:
Yearly Well Child Check		
Acute Problem Visits		

Vaccines: I've had my child vaccinated against or continue to protect against:

Flu Covid-19 Tetanus

All Childhood Vaccinations (MMR, Hepatitis, Chicken Pox, Polio, Hib, Rotavirus, etc)

I don't believe in vaccines for my child