Our Providers

Cristi Wilson, MD

Dr. Wilson graduated from The Medical College of Virginia in 1987. Her postgraduate training in Pediatrics continued at MCV from 1987-1990 where she received the MCV Department of Pediatrics Emily Gardner Award. Dr. Wilson became Board Cerified in Pediatrics in 1990.

Dr. Wilson has practiced Pediatrics in the Richmond area since 1990 and formed Henrico Pediatrics at that time

Adam Falik, MD

Dr. Falik graduated from The George Washington University School of Medicine in 1997. His postgraduate training in Pediatrics was at Children's National Medical Center in Washington, DC. Dr. Falik started here at Henrico Pediatrics in 2000.

HENRICO PEDIATRICS, P.C.

7605 Forest Avenue, Suite 102 Richmond, VA 23229 Phone: (804) 288-3069 Fax: (804) 288-5464

PATIENT NAME: _____ LAST _____ FIRST _____ MIDDLE _____ M F SEX _____ DATE OF BIRTH

PREFERRED LANGUAGE

( ) ENGLISH ( ) SPANISH ( ) OTHER_____.

ETHNICITY

( ) HISPANIC OR LATINO ( ) NOT HISPANIC OR LATINO
( ) DECLINE TO SPECIFY ( ) UNKNOWN

RACE

( ) AMERICAN INDIAN OR ALASKAN NATIVE ( ) ASIAN ( ) BLACK OR AFRICAN-AMERICAN
( ) HAWAIAN NATIVE OR PACIFIC ISLANDER ( ) WHITE ( ) DECLINE TO SPECIFY

PREFERRED CONTACT METHOD FOR MEDICAL ISSUES: ( ) HOME PHONE ( ) CELL PHONE ( ) WORK PHONE

FATHER'S NAME: _____ SS#: _____ DOB: _____

FATHER'S ADDRESS: _____ STREET _____ CITY _____ ZIP

FATHER'S EMPLOYER: _____ E-MAIL: _____

FATHERS HOME #: _____ CELL #: _____ WORK #: _____

MOTHER'S NAME: _____ SS#: _____ DOB: _____

MOTHER'S ADDRESS: _____ STREET _____ CITY _____ ZIP

MOTHER'S EMPLOYER: _____ E-MAIL: _____

MOTHER'S HOME #: _____ CELL #: _____ WORK #: _____

PHARMACY: _____ PHARMACY PHONE #: _____

EMERGENCY CONACT: _____ CONTACT'S PHONE #: _____
(OTHER THAN PARENTS)

RESPONSIBLE PARTY FOR VISIT: PARENT ( ) GUARDIAN ( )

RECEIPT OF PRIVACY PRACTICES WRITTEN AKCNOWLEDGEMENT

I, _____ PARENT/GUARDIAN, HAVE RECEIVED A COPY OF HENRICO PEDIATRICS, P.C. NOTICE OF PRIVACY PRACTICES.

COPY OF INSURANCE CARD & VIRGINIA STATE LICENSE

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL COPAYS AND THOSE CHARGES DENIED BY THE INSURANCE FOR ANY REASON REGARDLESS OF INSURANCE COEGERAGE. COPAYS ARE DUE THE DAY SERVICES ARE RENDERED AS WELL AS NON-COVERED CHARGES BY YOUR INSURANCE, WHICH ARE TO BE PRE-DETERMED BY THE PATIENT IN ADVANCED OR VERIFIED BY HENRICO PEDIATRICS, P.C.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HERBY AUTHORIZE HENRICO PEDIATRICS, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HERBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS. I UNDERSTAND THAT I, THE PARENT / GUARDIAN AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I FURTHER AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY FEES, COURT FEES, WHETHER SUIT IS BROUGHT OR NOT, IN THE EVENT THAT PAYMENT FOR SERVICES RENDEREDIS NOT MADE WHEN BILLED.

_____ PATIENT/PARENT/GUARDIAN'S SIGNATURE

_____ DATE

HENRICO PEDIATRICS, P.C.

7605 FOREST AVE. SUITE 102
RICHMOND, VA 23229
PHONE: 804-288-3069
FAX: 804-288-5464

CONSENT TO TREAT

CONSENT TO TREAT MINOR CHILDREN IN GUARIAN'S ABSENCE
PLEASE PRINT ALL INFORMATION

I, _____, PARENT OR LEGAL GUARDIAN OF
(child's name) _____ (DOB: _____/_____/_____),
Do hereby consent for the following individuals age 18 or older to discuss or obtain medical treatment for the child listed above.

******PLEASE NOTE THAT IF THE PERSON IS NOT ON THIS LIST WE CAN NOT GIVE THEM ANY INFORMATION**
NOR WILL THEY BE ABLE TO BRING YOUR CHILD TO AN APPOINTMENT IF YOU ARE NOT ABLE TO BRING THEM. WE MUST HAVE WRITTEN CONSENT BY THE PARENT OR GUARDIAN ****

MOTHER'S NAME _____ FATHER'S NAME _____

PLEASE LIST ANY OTHER ADDITIONAL PEOPLE BELOW THAT YOU WILL ALOW US TO SPEAK WITH OR TO BRING YOUR CHILD TO OUR OFFICE. (EXAMPLE; GRANDPARENTS, AUNT, UNCLE, FRIEND, ECT..)

_____ NAME	_____ RELATIONSHIP TO PATIENT
_____ NAME	_____ RELATIONSHIP TO PATIENT
_____ NAME	_____ RELATIONSHIP TO PATIENT
_____ NAME	_____ RELATIONSHIP TO PATIENT

This authorization is effective until revoked in writing or until ____/____/_____. (If you do not want this to expire please leave date blank.)

_____ Signature of parent or legal guardian	_____ Date	_____ Printed name

INSURANCE INFORMATION

Person Responsible for Insurance: Last: _____ First: _____

Relationship to Patient: _____ DOB: _____ S.S. # _____

Address (if different than patients): _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ **Contact # :** _____

Subscriber ID: _____ **Group # :** _____

Name of Insured on Card: _____

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

SECONDARY INSURANCE

Insurance Company: _____ **Contact # :** _____

Subscriber #: _____ **Group # :** _____

I _____ have acknowledged the information above is correct. I understand that putting in the wrong insurance could result in possible billing issues or fees.

SIGNATURE: _____ **DATE:** _____

HENRICO PEDIATRICS, P.C.
7605 Forest Avenue, Suite 102 Richmond, VA 23229 Phone: (804) 288-3069 Fax: (804) 288-5464

Cristi S. Wilson, M.D. Adam M. Falik, M.D.

Authorization for Release of Medical Information

_____ _____
Name of Child Date of Birth

_____ _____
Name of Child Date of Birth

_____ _____
Name of Child Date of Birth

Information requested:

Office Notes Lab / X-Ray Financial History

Immunizations Entire Chart Other _____

INFORMATION TO BE RELEASED **FROM**:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

I HEREBY REQUEST THAT THE MEDICAL DOCUMENTS LISTED ABOVE BE FORWARD **TO**:

Henrico Pediatrics – Medical Records
7605 Forest Avenue, Suite 102
Richmond, VA 23229
Fax: (804) 288-5464

Reason for Request:

___Transfer of Care ___Relocation ___Other _____

_____ _____
Signature of Parent Date

_____
Phone # to reach parent if needed

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

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

General DK = don't know

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

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

Henrico Pediatrics, P.C.

OFFICE POLICIES AND PROCEDURES

Well Child Check-Ups

To ensure you and your child receive quality time at each visit, we require all check-ups to have a scheduled appointment to be seen. For your child to receive a complete check-up with immunizations that may be needed, we must have the child's immunization record at least 24 hours before the scheduled appointment. If we do not receive them by then, you will be asked to reschedule for a later time and date. Please arrive on time, bring your insurance card, photo ID, and co-pay if your insurance requires one. Well Child Check-Ups are scheduled appointments; therefore, if you are more than 15 minutes late for your appointment, you will be asked to reschedule for a later time and date.

No Show Policy

We understand there are times when you are unable to keep your child's appointment. When the scheduled time lot is unused, it prevents another patient from having access to the physician. If you need to cancel or reschedule your appointment, please give our office 24-hour notice or there will be a charge. The first no show will result in a warning letter. After the first warning, we will charge a fee of $25.00 per no show appointment. Excessive no show may result in dismissal from our practice for not adhering to our office policies.

Walk-Ins

For all sick visits, newborn visits, labs and follow-ups from the ER, you do not have to schedule an appointment. You may bring your child in during our walk-in hours: Monday – Friday from 8:30 am -11:30 am and 1:30 am -4:30 pm. The office will be closed from 12:00 pm -1:00 pm.

ADHD & Pre-OP Appointments

For visits regarding ADHD and Pre-ops, please call and speak to one of the members of our front office team. The procedure for scheduling these types of appointments varies from physician to physician.

Immunizations

For all make-up vaccines, HPV vaccines (Gardasil), Tdap Boosters (required for 6th grade) we ask that patients walk-in during our walk-in hours. Your child must have an up-to-date check-up to receive any vaccines.

Consent to Treat – It is the Law

The law requires that all patients under the age of 18 to be accompanied by a parent or legal guardian to every office visit. However, we can accept written permission from the parent or legal guardian allowing individuals aged 18 years or older to bring the patient in and make medical decisions on behalf of the parent or legal guardian. The permission must be in writing, and we cannot receive permission over the phone or by e-mail due to HIPAA regulations. It can be faxed, mailed, or provided to the staff at the time of the visit. We must obtain written permission before the child is seen.

Medical Records

If your child is 18 years or older, we cannot release any medical information to the parent or legal guardian without consent from the patient. This includes requesting medical records or talking to the physician or nurse about any medical problems. The patient can fill out a form in our office giving the parent or legal guardian permission to request medical records and discuss medical problems with the parent or legal guardian. It is a HIPAA regulation we must abide by.

To request medical records please be aware because all medical records are governed under federal law, you must do one of the following:

Supply to our office a written request authorizing Henrico Pediatrics, P.C. to release the requested medical records you need, along with your child's name, date of birth, and the fax number of where you want the medical records faxed to. Please make sure you sign and date the request. You may also come by our office and fill out a medical records release form. Please be aware that all medical records requests require a minimum of 72 business hours to be processed.

For medical records to be released to anyone other than a physician's office there is a $10.00 search and handling fee, plus $0.50 per page up to 50 pages and $0.25 per page after the 50th page. There is no charge for records released directly to another physician's office via fax.

Medical Forms

All medical forms needed to be filled out by a physician require 48-72 business hours to be completed. This includes school entrance forms, sports physicals, school medication forms, etc. We ask that you make sure any portion of a form needed to be filled out by a parent or legal guardian is completed prior to dropping it off for a physician. Ion order for these forms to be completed by the physician, your child must have an up-to-date check-up.

Prescription Refills

To request a prescription refill, please call our office and follow the touch tone prompts to reach your physician's nurse. All prescription requests require 24-48 business hours to be processed.

Insurance

Co-payments are due and payable at the time of visit. We accept payments of cash, checks and credit cards (Visa, MasterCard, Discovery and American Express). If a claim is denied because you have not provided correct insurance information at the time of your visit, the charges will transfer to your respo9nsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab service, immunizations and other procedures.

Self-Pay

If proof of insurance is not provided, your account will be considered self-pay and payment in full of all charges will be required at the time of service. If you subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will bill the charges to your insurance company for you. If we then receive insurance payment, we will promptly issue a refund to you of any credit on your account.

Returned Checks

There is a $35.00 returned fee in the event a patient's personal check is returned to us for any reason.

Mutual Respect

Henrico Pediatrics believes a safe, caring environment is vital to the success of both our patients and our practice. With this in mind, we also expect our staff to be met with the same level of dignity and respect that is shown to you and your family.

Profanity, Verbal Threats, Abuse and Violence will not be tolerated in any way and may lead to dismissal from our practice.

The undersigned has read and agrees to the policies of Henrico Pediatrics, P.C.

Printed Name:_____Date:_____

(Parent/Guardian/Responsible Party)

Signature:_____Date:_____

(Parent/Guardian/Responsible Party)

Please print the name of each child of yours that are patients at our practice.

_____

Name of Child Date of Birth

_____

Name of Child Date of Birth

_____

Name of Child Date of Birth

_____

Name of Child Date of Birth