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

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

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.
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CONSENT TO TREAT MINOR CHILDREN IN GUARDIAN'S ABSENCE

Please print all information.

I, _____, parent or legal guardian of

_____, born on _____, do hereby consent

for the following individuals age 18 years or older (*write below the first and last name of*, i.e., Grandparents, Aunt, Uncle, Babysitter, Friend, etc.) to discuss and/or obtain medical treatment for the child listed above.

** Please include parents and /or guardians. **

_____	_____
(Individual(s) caring for your child)	***(Relationship to Patient)***
_____	_____
(Individual(s) caring for your child)	***(Relationship to Patient)***
_____	_____
(Individual(s) caring for your child)	***(Relationship to Patient)***
_____	_____
(Individual(s) caring for your child	***(Relationship to Patient)***

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

_____ _____
Signature of Parent or Legal Guardian Date

_____
Name of Parent or Legal Guardian *(please print)*

Form Furnished By U.S. CDC (Center for Disease Control)

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. Charlotte A. McKnight, 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

HENRICO PEDIATRICS, P.C.

1. Please read about each of our physicians, and then **check (✓) next to one of the physicians name** to serve as your child's primary pediatric provider.

2. Please remember to **call the member service 800 # on the back of your insurance card,** so that they can update their records to insure all claims are properly processed.

Dr. Cristi S. Wilson ( )

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 prestigious MCV Emily Gardner Award for being the top ranking resident in the field of Pediatrics. Dr. Wilson became Board Certified in Pediatrics in 1990. Dr. Wilson currently holds a clinical instructor position on faculty at Virginia Commonwealth University's Medical College of Virginia.

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

Dr. Adam M. Falik ( )

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, D.C. from 1997-2000. Dr. Falik has been Board Certified in Pediatrics since 2000.

Dr. Falik has been practicing Pediatrics in the Richmond area since 2000 when he joined Henrico Pediatrics. His daughter was happy to pose with him in this photo!

Dr. Charlotte A. McKnight ( )

Dr. McKnight completed her undergraduate education in her home state at the University of Missouri. She spent time in Germany, where her husband was stationed with the United States Air Force, then returned to the Midwest for medical school at the University of Nebraska.

She completed her pediatric residency training at Virginia Commonwealth University where she received the prestigious Emily Gardner Award for being the top ranking resident in the field of Pediatrics. She joined HENRICO PEDIATRICS, April 16, 2018.

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. Thank you!

_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth

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 and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

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

General

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

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

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

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

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

Is your child allergic to any medicines or drugs? ☐ 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 _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain	_____
Any other significant problem	☐ Yes	☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain	_____

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OFFICE POLICIES & 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 in order to be seen. In order 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 that there are times when you are unable to keep your child's appointment. When the scheduled time slot 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 a 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 shows 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 8:30am-11:30am and 1:30pm-4:30pm. The office will be closed from 11:30am-1:30pm for lunch.

ADHD & Pre-Op Appointments

For visits regarding ADHD and Pre-ops, please call and speak to one of the members of the front desk. 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 Tuesday-Thursday to receive the immunizations. Your child must have an up to date check-up in order to receive any vaccines.

Saturday Hours of Operation

On Saturdays, the office will be open from 8:30am-11:00am for urgent care sick visits only. We ask that patients arrive in the office by 10:30am to be seen; however, we will continue to see patients up until 11:00am. Due to the limited staff, we do not give immunizations or schedule check-ups on Saturdays. Since Saturdays are outside of our regular Monday-Friday business hours, there is an extra fee charged for urgent care Saturday morning visits.

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 age 18 years or older to bring the patient in and make medical decisions on the behalf of the parent or legal guardian. ***The permission must be in writing and we can not 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 can not 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 that we must abide by.*

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

Fax 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 them faxed. 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 record 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. In 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, 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 responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Self Pay

If proof of insurance is not provided, your account will be considered a 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 $25 returned check fee in the event a patient's personal check is returned to us for any reason.

Billing Questions

To make a payment on your account, or if you have any billing questions please contact our billing company at 804-281-3781.