Pediatric & Adolescent Healthy Lifestyle Center

New Patient Form

Patient Name: _____Date of Birth: _____ Gender: F M

Home address:_____
Street City State Zip

How did you hear about our office? _____

Mother's Name:_____
Date of Birth:___/___/___Phone:_____
Home address
_____
Street
_____
City Zip
❑ Same as above
Email _____

Father's name: _____
Date of Birth: ___/___/____ Phone:_____
Home address
_____
Street
_____
City Zip
❑ Same as above
Email _____

Emergency Contact: Please list someone other than parent
Name: _____Relationship to patient: _____Phone:_____

Responsible Party/Primary Insurance Information
Insured's name: _____
Date of Birth: _____ SSN:_____
Employer:_____
Insurance carrier name:_____
Policy ID:_____
Group Number:_____

Secondary Insurance Information
Insured's name:_____
Date of Birth: _____ SSN:_____
Employer:_____
Insurance carrier name:_____
Policy ID:_____
Group Number:_____

Authorization to Treat and Release Medical Information

I attest that I have legal authority to make medical decisions on behalf of the patient, and that if this situation changes, I will inform Pediatric and Adolescent Healthy Lifestyle Center of this change in writing.

I hereby authorize Pediatric and Adolescent Healthy Lifestyle Center to perform medical evaluation & treatment, concerning my healthcare and treatment. I also authorize Pediatric and Adolescent Healthy Lifestyle Center to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. Hence, I authorize payments directly to Pediatric and Adolescent Healthy Lifestyle Center of the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due Pediatric and Adolescent Healthy Lifestyle Center. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

Signature of Patient or Legal Guardian_____ Date ___/___/____

_____
Name Relationship to patient

Pediatric & Adolescent Healthy Lifestyle Center

Medical History Questionnaire

Patient Name: _____Date of Birth: : _____

Medical conditions (circle all that apply)

Asthma Heart disease
Diabetes Autism
ADHD
Eczema Other_____

Current Medications:

Name: _____ Dosage: _____
Name:_____ Dosage: _____

Past Hospital Admission: Month/Year: ____/____
Diagnosis: _____

Allergic to Medication or food:_____ Type of reaction: _____
Medication or food:_____ Type of reaction: _____

Birth

Birthweight_____ Birth Hospital_____

Was this child born at:

- ❑ 37 weeks or more
- ❑ Less than 37 weeks

Was delivery(circle): Vaginal Cesarean
Breech Multiple birth (twin/triplet)

Growth and Development

At what age did this child:

Walk unsupported: _____
Speak words: _____
Speak sentences:_____
Get toilet trained: _____
Describe any current developmental difficulties_____

Who lives with this child:

- ❑ Mother
- ❑ Father
- ❑ Brothers(ages):_____
- ❑ Sisters(ages): _____
- ❑ Grandmother
- ❑ Grandfather

Siblings:

Name: _____M F Date of Birth: ___/___/___
Name: _____M F Date of Birth: ___/___/___
Name: _____M F Date of Birth: ___/___/___
Name: _____M F Date of Birth: ___/___/___

Does anyone living in this house smoke?
No Yes
Are there pets in the home?
No Yes (what kind)_____

Mother's Occupation: _____
Father's Occupation: _____

Do parents work with (circle all that apply):
Metal Chemicals Ceramics
Lead Paint striping

Type of heat source in home (circle):
Electric Gas Oil
Kerosene Wood stove

Family Medical History

Does child's birth parents(M,F), siblings(B,S), aunts(MA, PA), uncles(MU,PU) or grandparents(MGF,MGM,PGF,PGM) have any of the following:

Condition	Affected Family Member	Condition	Affected Family Member	Condition	Affected Family Member
High Blood Pressure		Heart Attack or Stroke before age 55		Hearing Problems	
Diabetes		Emotional Problems		Headaches	
Asthma		Allergies		GI disease	
Cancer		Autism		Psychiatric disorder	
High Cholesterol		ADHD		Alcohol/Drug Addiction	
Epilepsy / Seizures		Mental Retardation		Vision Problems	
Kidney disease		Liver disease		Blood disorder	

2525 Ogden Avenue, Downers Grove, IL 60515
Phone:630-929-3009
408 N. Ardmore Avenue, Villa Park, IL 60181
Fax: 630-310-8614

Pediatric & Adolescent Healthy Lifestyle Center

Receipt of Privacy Policies

Patient Name: _____Date of Birth: _____

Acknowledgement of Privacy Policies

I, _____ , have received a copy of Pediatric and Adolescent Healthy Lifestyle Center's Notice of Privacy Practices.

The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. A copy of the Notice is available in the reception area. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via a posting in the reception area of Pediatric and Adolescent Healthy Lifestyle Center. The practice receptionists will be calling your home)or work if home phone is not available) with appointment reminders. They will leave as little information as possible. Additionally, the physicians and nursing staff often need to speak with you regarding medical issues. Please assist our medical staff by telling the following: what type of message can be left, where it can be left, and who it may be left with

This notice is valid for all family members that receive medical services at this practice.

Please list your children's names below.

_____

_____

_____

_____

_____

Please select **all** that apply:

- ❑ I do not give this practice and its representatives consent to leave messages with **anyone other than parents or legal guardians.**
- ❑ I give this practice and its representatives consent to **leave messages on my voicemail or answering machine**.
- ❑ I do not give this practice and its representatives consent to leave messages with my voicemail or answering machine.
- ❑ I give this practice and its representatives consent to **leave messages with the following person(s):**

Signature of Patient or Legal Guardian_____ Date ___/___/____

_____

Name Relationship to patient

Pediatric & Adolescent Healthy Lifestyle Center

Office Financial Policies

Patient Name: _____ Date of Birth: _____

We would like to thank you for choosing Pediatric and Adolescent Healthy Lifestyle Center (aka Pahl Center) as your child's healthcare providers. We are committed to providing you with the best care possible while maintaining a good physician-patient relationship. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the healthcare providers of this practice and you, the parent/guardian. Your clear understanding of the financial policy agreement is important to our professional relationship. We require a signature to document that you have read and understand these policies.

Please inform us of your move to a new address. If you fail to inform us it may result in delinquent bills or a collections account. Insurance changes are very important to update immediately. Failure to do so can result in our inability to file claims for you. All insurance companies have deadlines for filing claims (90 days-1 year). If we fail to make a deadline as a result of inaccurate insurance information, you are responsible for the balance.

Appointments: We reserve the right to charge a fee for missed appointments. A $25 fee will be charged for a second missed appointment.

Insurance: It is your responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the insurance company you designate is incorrect, you will be responsible for payment for the visit and to submit the charges to the correct plan for reimbursement.

Payment

You are responsible for any and all co-payments, deductibles, and coinsurances.

The person who brings the child is responsible for any and all co-payments, deductibles, coinsurances or balances.

- Co-payments are due at the time of service. A $25 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
- Self-pay patients are expected to pay for services in FULL at the time of the visit.
- If we do not participate in your insurance plan, payment in FULL is expected from you at the time of your visit. We will supply you with an invoice to submit to your insurance for reimbursement.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of receipt of your bill.
- If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a $25 re-bill fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
- Pahl Center accepts cash, personal checks, VISA, and MasterCard.
- A service charge of $25 will be charged for returned checks.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Signature of Patient or Legal Guardian_____ Date ___/___/____

_____

Name Relationship to patient

2525 Ogden Avenue, Downers Grove, IL 60515 408 N. Ardmore Avenue, Villa Park, IL 60181
Phone: 630-929-3009 Fax: 630-310-8614

Vaccine Policy Statement and Consent to Vaccinate

As your primary healthcare provider, we are dedicated to the health and well-being of your child, and as such firmly believe in the importance of vaccinating children and adolescents. As a parent or caregiver, your decision to immunize your child is a direct way of proactively improving your child's health and preventing infections. The recommended vaccines and their schedules are a result of many years of scientific study and analysis of accumulated data on millions of children and by numerous scientists and health experts. Prevention of death and disability by vaccine preventable disease is the cornerstone of Pediatric practice. Hence:

- We firmly believe in the safety of our vaccines
- We firmly believe in the effectiveness of vaccines to prevent vaccine preventable disease, and so save lives and prevent death and disability
- We adhere to and strictly follow the vaccine recommendations and schedule as published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics
- At this time, there is no validated literature to support the claim that vaccines are linked to autism or other developmental disabilities

Please feel free to discuss any questions or concerns you may have about vaccines with Dr. Akin prior to your first visit.

If you should absolutely refuse to vaccinate your child in spite of all our efforts, we will ask you to find another healthcare provider who shares your views.

In signing this document, I hereby consent to having my child receive vaccinations at the Pediatric and Adolescent Healthy Lifestyle Center.

Acknowledgement of Receipt of Pahl Center Vaccine Policy and Consent to Vaccinate

Patient Name _____ DOB _____ Date _____

Signature of Patient or Legal Representative _____

Printed Name of Patient's Representative _____

Witness _____