BATH COMMUNITY PHYSICIANS GROUP

Pediatric New Patient Packet

PATIENT WELCOME

Welcome to Bath Community Physicians Group and thank you for choosing our clinic as your provider for medical care. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who consistently strive to exceed your expectations to ensure your experience with us is as comfortable and stress-free as possible.

We have four convenient locations: Hot Springs, Covington (Monroe Ave. and Riverside St.) and Millboro. Office hours can vary by location. To learn more about our hours of operation, please visit our website: http://bathhospital.org.

To provide access promptly, improve convenience, and become more efficient, we have centralized phone calls to Bath Community Physicians Group. We have a toll free number which will call into our switchboard to handle all your medical care needs. Our switchboard operators can send messages to your provider and nurse, answer questions, and schedule appointments.

Call Toll Free (866) 839-7100, Option 2

While we strive to schedule appointments appropriately, primary care emergencies occur. Our goal is to provide all patients with the time they require and deserve. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

CANCELLATION OF AN APPOINTMENT

To be respectful of the medical needs of our patients, please be courteous and call Bath Community Physicians Group promptly if you cannot attend an appointment. We will reallocate your time. This is how we can best serve our patients' needs. If it is necessary to cancel your scheduled appointment, we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

LATE FOR APPOINTMENT

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We will strive to stay on time. From time to time a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

NO SHOW POLICY

A "no-show" is the term we use when a patient misses an appointment without canceling it within one (1) business day. Unfortunately, "no-shows" inconvenience those patients who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no-show". A letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance will be mailed to you. A copy of the letter will be placed in your medical record. As a reminder, continued missed appointments may result in termination of our provider-patient relationship.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

- If you are scheduled for an appointment, you will receive a telephone call from our switchboard operators.
- Closings will be displayed at the clinic and on local radio stations.
- Closings will be displayed on our website and on Facebook.

INSURANCE

- Bath Community Physicians Group accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at 540-839-7175.
- It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.
- All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage.

PAYMENTS

- Patients are responsible for co-pays at time of service.
- If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.
- Bath Community Physicians Group accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Bath Community Physicians Group.
- It is the policy of Bath Community Physicians Group to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

- Please inform Bath Community Physicians Group of which Pharmacy you use and update us if this should change. Please allow two to three business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.
- Please note that we do not fill Narcotic Medications or order Antibiotics over the phone, as you will need to see your provider for this care.
- Our Practice does not routinely order Narcotic Pain medicine; therefore, you may be required to obtain these medications through a Pain Management specialist.

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

COMPLETION OF FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Bath Community Physicians Group will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time-consuming, please allow 7-14 days for the completion of the requested forms/letters. There are charges posted in the clinics associated with the completion of these forms/letters.

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Bath Community Physicians Group New Patient Packet.

_____

Printed Name

_____ _____

Signed Name **Date**

PATIENT REGISTRATION FORM – CONFIDENTIAL

PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐ Jr. ☐ Sr. ☐II ☐III ☐ Other

Preferred Name _____ **SSN** _____ **Date of Birth** _____ **Legal Sex** ☐Male ☐Female

Gender Identity ☐Male ☐Female ☐Transgender male (female-to-male) ☐Transgender female (male-to-female) ☐ Other ☐Choose not to disclose

Sex Assigned at Birth ☐Male ☐Female ☐Unknown ☐Not Recorded on Birth Certificate ☐Choose Not to Disclose

Patient Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Their ☐ Patient's Name ☐ Decline to Answer

Physical Address (Required) _____ **City/State/Zip** _____

Mailing Address *(If different)* _____ City/State/Zip _____

Preferred Phone (____) _____ - _____ ☐Home ☐Cell ☐ Work ☐Other

Secondary Phone (____) _____ - _____ ☐Home ☐Cell ☐ Work ☐Other

Primary Care Provider _____ ☐ M.D. ☐ N.P. ☐ P.A. **Phone** (____) _____ - _____

Primary Care Provider Location _____ Fax (____) _____ - _____

Employer _____ ☐ Full ☐P/T **Email** _____

Preferred Language _____ ☐ Interpreter Needed **Religion** _____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

Race/Physical Feature(s) ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐White ☐Choose Not to Disclose ☐Other ☐Unknown

Ethnicity/Culture ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Choose Not to Disclose

Pharmacy Choice _____

EMERGENCY CONTACTS

Primary Emergency Contact _____ **Relationship to Patient** _____

Primary Phone (____) _____ - _____ ☐Home ☐Cell ☐Work ☐Other

Secondary Phone (____) _____ - _____ ☐Home ☐Cell ☐Work ☐Other

Secondary Emergency Contact _____ **Relationship to Patient** _____

Primary Phone (____) _____ - _____ ☐Home ☐Cell ☐Work ☐Other

Secondary Phone (____) _____ - _____ ☐Home ☐Cell ☐Work ☐Other

RESPONSIBLE PARTY (GUARANTOR)

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ _Sr. ☐II ☐III ☐ Other

Relationship to Patient _____ **SSN** _____

Date of Birth _____ **Legal Sex** ☐Male ☐Female ☐Decline to Answer

Physical Address (Required) _____ **City/State/Zip** _____

Mailing Address *(If different)* _____ City/State/Zip _____

Preferred Phone (____) _____ - _____ ☐Home ☐Cell ☐ Work ☐Other

Secondary Phone (____) _____ - _____ ☐Home ☐Cell ☐ Work ☐Other

Employer _____ ☐ _Full ☐P/T **Email** _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber Name _____ **SSN** _____ **Date of Birth** _____

Address (if different from above)_____ City/State/Zip _____

Subscriber Number PCP _____ **Effective Date** _____ **Group Number** _____

Group/Employer Name _____

Physical Address _____ City/State/Zip _____

Secondary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above)_____ City/State/Zip _____

Subscriber Number PCP _____ **Effective Date** _____ **Group Number** _____

Group/Employer Name _____

Physical Address _____ City/State/Zip _____

COMMUNICATION PREFERENCE

Check all that apply ☐MyChart ☐Text ☐Phone ☐Mail

☐ **Check here if you'd like for Bath Community Hospital to provide information about our newest services, products and offerings. You may opt out at any time.**

Thank you for choosing Bath Community Physicians Group.

PEDIATRIC MEDICAL HISTORY FORM

Legal Name: _____ **DOB:** _____ **Date:** _____

Preferred Name *(if different from above):* _____

Adopted?	☐ Y	☐ N
Foster Child?	☐ Y	☐ N

Who lives in child's household?

Please list all operations or hospitalizations, including year:

_____

_____

_____

Any other adults involved in the child's care?

Do you want to authorize any individuals the release of your child's information or permission to participate in child's appointment?

Medication Allergies/Intolerances:
(list the reaction that occurs)

_____

_____

_____

Personal Medical History: Check Yes or No, *explain yes answers (when occurred or was diagnosed)*

Abdominal Pain	☐ Y	☐ N
Abuse: ☐ Physical ☐ Mental ☐ Sexual	☐ Y	☐ N
Acne	☐ Y	☐ N
ADD/ADHD	☐ Y	☐ N
Allergies	☐ Y	☐ N
Anemia	☐ Y	☐ N
Anxiety Disorder	☐ Y	☐ N
Arthritis	☐ Y	☐ N
Asthma	☐ Y	☐ N
Bleeding Disorder	☐ Y	☐ N
Bronchiolitis	☐ Y	☐ N
Cancer	☐ Y	☐ N
Chicken Pox	☐ Y	☐ N
Concussion	☐ Y	☐ N
Congenital Heart Disease	☐ Y	☐ N
Constipation	☐ Y	☐ N
Depression	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Eczema	☐ Y	☐ N
Fracture	☐ Y	☐ N
GE Reflux/Heartburn	☐ Y	☐ N
Headaches	☐ Y	☐ N
Hearing Problems	☐ Y	☐ N
Heart Murmur	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N
Kidney Infection	☐ Y	☐ N
Menstrual Problems (females)	☐ Y	☐ N
Migraines	☐ Y	☐ N
Pneumonia	☐ Y	☐ N
Prematurity	☐ Y	☐ N
Recurrent Ear Infections	☐ Y	☐ N
Seizure Disorder	☐ Y	☐ N
Sleep Problems	☐ Y	☐ N
Urinary Tract Infection	☐ Y	☐ N
Other Serious Illness	☐ Y	☐ N

_____

_____

Family History (Blood Relatives)

	Age at death	If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brother(s) and Sister(s)		
1		
2		
3		
4		

Family Medical: Have any family members had (Check if yes):

☐ ADD/ADHD	☐ Genetic Disorder
☐ Allergies	☐ Heart Problems
☐ Anemia	☐ High Cholesterol
☐ Asthma	☐ High Blood Pressure
☐ Birth Defects	☐ Learning Disability
☐ Blood Disorder	☐ Mental Illness
☐ Cancer	☐ Mental Retardation
☐ Curved Spine	☐ Migraines
☐ Deafness	☐ Obesity
☐ Depression	☐ Seizure Disorder
☐ Developmental Delay	☐ Sudden Infant Death
☐ Diabetes	☐ Thyroid Disease
☐ Drug/alcohol abuse	☐ **Other:**
☐ Eczema	_____

Safety

Is there a smoke alarm in the home?	☐ Y	☐ N
Carbon monoxide alarm in the home?	☐ Y	☐ N
Guns in the household?	☐ Y	☐ N
Secondhand tobacco smoke?	☐ Y	☐ N
Prescription pain meds in the home?	☐ Y	☐ N
Marijuana or other drug use in the home?	☐ Y	☐ N

Medications

Is the patient currently taking any medications?	☐ Y	☐ N
If yes, which ones?		
Any daily over-the-counter medications?	☐ Y	☐ N
If yes, which ones?		

PEDIATRIC HISTORY QUESTIONNAIRE

For children up to 3 years old:

Delivery/Newborn Period:	**Birth History:** During pregnancy, did mother:		
Delivery Type (check): ☐ Vaginal ☐ C-Section	Smoke?	☐ Y	☐ N
Birth Weight: _____	Drink alcohol?	☐ Y	☐ N
Problems in Newborn Period: _____	Use Drugs/Medications?	☐ Y	☐ N
	Experience illness?	☐ Y	☐ N

For children to 3 to 9 years old:

Where does your child go to school? ☐ Y ☐ N	What grade? _____		
Has your child repeated or been held back a grade?		☐ Y	☐ N
Has your child attended a special class?		☐ Y	☐ N
Does your child have behavior problems at school?		☐ Y	☐ N
Has your child had any bullying problems?		☐ Y	☐ N
How much screen time (video, TV, computer, phone) during a typical day? _____ hours per day			

For children 10 to 12 years old:

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?		☐ Y	☐ N
Has your child attended a special class?		☐ Y	☐ N
Does your child have behavior problems in school?		☐ Y	☐ N
Has your child had any bullying problems?		☐ Y	☐ N
Any academic problems?		☐ Y	☐ N
How much screen time (video, TV, computer, phone) during a typical day? _____ hours per day			
Any concerns about body image?		☐ Y	☐ N
Please explain any Yes answers:			

For children 13 to 18 years old:

Where does your child go to school?	What grade?		
Does your child have behavior problems in school?		☐ Y	☐ N
Has your child had any bullying problems?		☐ Y	☐ N
Any academic problems?		☐ Y	☐ N
How much screen time (video, TV, computer, phone) during a typical day? _____ hours per day			
Any concerns about body image?		☐ Y	☐ N
Concerns about sexuality?		☐ Y	☐ N
Do you use alcohol?		☐ Y	☐ N
Po you use tobacco or vape?		☐ Y	☐ N
Do you use caffeine, coffee, tea, soda, power drinks?		☐ Y	☐ N
Do you use “recreational drugs”?		☐ Y	☐ N
Are you sexually active?		☐ Y	☐ N
If yes, with whom? ☐ Males ☐ Females ☐ Both			
Do you see a dentist? Who?		☐ Y	☐ N
Any concerns for depression or anxiety?		☐ Y	☐ N
Have you ever been abused? ☐ Physically ☐ Sexually ☐ Both		☐ Y	☐ N
Are you satisfied with your weight?		☐ Y	☐ N
Menstrual periods? What age? _____		☐ Y	☐ N
Do you exercise? How often? _____ What type? _____		☐ Y	☐ N
Do you always wear a seat belt?		☐ Y	☐ N
If you ride a bike or motorcycle, do you always wear a helmet?		☐ Y	☐ N
Are guns kept in your home?		☐ Y	☐ N
If yes, is the household aware of gun safety?		☐ Y	☐ N

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name: _____ **Date of Birth:** _____

_____ (Patient/Representative initials) **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health care information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that that I may contact the Chief Compliance Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **RELEASE OF INFORMATION**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other BHC affiliated facilities may be made available to subsequent BCH-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes and such other purposes as my be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, Findings and care decisions to the family members and others listed below:

	Name	**Relationship**	**Contact Number**
1.			
2.			
3.			

CONSENT TO MEDICAL CARE

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL TO BRING YOUR CHILD TO OUR OFFICE FOR MEDICAL TREATMENT? *If yes, please fill out the section below.*

I (the parent or legal guardian) am the lawful guardian of the child named below. I give permission and consent to:

Name: _____

Address: _____

_____

Phone Number: (____) _____-_____

Relationship to Child: _____

to authorize medical treatment for:

Full Name of Child: _____

Child's Date of Birth: _____

This permission is granted from **(Date)** _____ and will expire on **(Date)** _____.

PERMISSION TO PICK UP PRESCRIPTIONS OR MEDICAL INFORMATION

DO YOU WANT TO GIVE PERMISSION TO A FAMILY MEMBER OR OTHER INDIVIDUAL TO PICK UP PRESCRIPTIONS OR MEDICAL INFORMATION FOR YOUR CHILD? *If yes, please fill out the section below.*

I (the parent or legal guardian) am the lawful guardian of the child named below. I give permission and consent to:

Name: _____

Address: _____

_____

Phone Number: (____) _____-_____

Relationship to Child: _____

to pick up prescriptions or medical information for:

Full Name of Child: _____

Child's Date of Birth: _____

This permission is granted from **(Date)** _____ and will expire on **(Date)** _____.

_____ _____

Patient Representative Signature **Date**

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

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