Pediatric Patient Questionnaire

PRIMARY CARE PCSM SPORTS MEDICINE

[ ] 18411 Clark Street, Suite 302
Tarzana, CA 91356

[ ] 29525 Canwood Street Suite 211
Agoura Hilla, CA 91301

Patient Information			
FIRST AND LAST NAME			
DATE OF BIRTH		[ ] MALE	[ ] FEMALE
HOME ADDRESS	CITY		STATE AND ZIP
PRIMARY PHYSICIAN	CITY		PHONE
PREFERRED PHARMACY	CITY		PHONE

MOTHER/FATHER FIRST AND LAST NAME	DATE OF BIRTH	HOME PHONE #	PRIMARY CELL PHONE #
EMAIL ADDRESS:		ADDRESS (IF DIFFERENT FROM ABOVE)	
MOTHER/FATHER FIRST AND LAST NAME	DATE OF BIRTH	HOME PHONE #	SECONDARY CELL PHONE #
EMAIL ADDRESS:		ADDRESS (IF DIFFERENT FROM ABOVE)	

MAY WE CONTACT YOU BY PHONE, EMAIL AND/OR TEXT MESSAGE? [ ] YES [ ] NO

GUARDIANSHIP (IF APPLICABLE)

HOW DID YOU HEAR ABOUT US? Please make 1 selection

[ ] Yelp [ ] Google [ ] Insurance [ ] Physician :_____ [ ] Urgent Care : _____

[ ] Physical Therapy: _____ [ ] School/Trainer: _____

[ ] Family Member: _____ [ ] Friend: _____ [ ] Returning Patient

INSURANCE CARRIER:	BILLING ADDRESS IF DIFFERENT FROM ABOVE
SUBSCRIBERS NAME AND DOB	

Patient Acknowledgement of PCSM Education Site

Here at Primary Care Sports Medicine, our doctors have a passion of teaching and instructing future doctors and other healthcare professionals by allowing them to participate in rotations and internships here in our clinic. This allows medical residents/students to get first hand experience in the area of non-surgical sports medicine.

Please note that your care plan will not be dictated by the resident's/student's involvement and you will always be evaluated by the provider with whom you are scheduled. Your willingness to contribute to the learning of these students/residents much appreciated and is a vital part of the experience of our future doctors and health professionals.

PLEASE READ CAREFULLY AND CHOOSE ONE OPTION ONLY

While providing this service is important to us, your comfort is more important. Please indicate below your preference.

___ **I AM** comfortable with having students/residents ***Observe, ask questions about my injury/nature my visit, take my vitals and perform a brief physical exam (only by a resident physician)*** during my visit to further their learning.

___ **I AM NOT** comfortable with having students/residents present during my visit.

___ **I AM** comfortable having students/residents **OBSERVE ONLY.**

Signature:_____ **Date:**_____

Relationship to patient: _____

Primary Care Sports Medicine
Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with excellent service and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to- date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

PRODUCT RETURNS: Products and medications which are prescribed for and dispensed to a patient may not be returned for any reason. Some product manufactures offer satisfaction guarantees and the patient may contact the manufacturer directly.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non- custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item including custom orthotics may not be returned for any reason.

MEDICAL RECORDS/FORMS: We will provide copies of patient records at the patient's request. Please provide our office 48 hours to complete your request. Additional Forms such as Disability, Accident Claims or forms requiring a "Physician Statement" will incur a **$25 fee**. You will be charged a **$5 fee** for digital X-Rays provided on CD.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. You will be charged a **$50 fee** for any appointment cancelled or rescheduled less than 24 hours of the scheduled time. If you arrive late for an appointment, we will do our best to accommodate you, however, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After final notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **40% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover/AMEX. An additional $45.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Primary Care Sports Medicine, AMC for medical services provided. I agree to pay Primary Care Sports Medicine, AMC any balance unpaid by my insurance carrier for myself or the below named person. **Initial Here: _____**

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms. **Initial Here: _____**

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Primary Care Sports Medicine, AMC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the provider and the practice to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the Primary Care Sports Medicine, AMC if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ Signature: _____

Patient Date of Birth: _____ Date Signed: _____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Please complete the following Medical Questionnaire

Review of Systems: (Please check all that you are CURRENTLY experiencing)

Constitutional:

☐Chills	☐Decline in Health	☐Fatigue
☐Fever	☐Weakness	☐Weight Gain
☐Weight Loss		

Head:

☐ Dizziness	☐Fainting	☐Head Injury
☐Headaches	☐ Pain	☐Sweats

Eyes:

☐ Blurry Vision	☐Discharge	☐ Double Vision
☐Eye Pain	☐Eyeglass Use	☐Pain with Light
☐Recent Injury	☐ Unusual Sensations	☐ Vision Loss

ENT:

☐ Discharge (nose)	☐Hay Fever	☐Infections
☐Nasal Obstruction	☐Nosebleeds	☐Sinus Infection
☐Discharge (ears)	☐ Hearing Aid	☐ Hearing Impairment
☐ Pain (ears)	☐Ringing in Ears	

Respiratory:

☐Asthma	☐Cough	☐Wheezing
☐Bronchitis	☐Coughing Blood	☐Pain
☐Pleurisy	☐ Positive TB Test	☐Recent Chest X-Ray
☐Short of Breath	☐Sputum	☐Tuberculosis

Cardiovascular:

☐Chest Pain	☐Palpitations	☐Extremity(s) Cool
☐Heart Murmur	☐High Blood Pressure	☐History of Heart Attack
☐Short of Breath-Exertion	☐Short of Breath-Lying Flat	☐Thrombophlebitis

Gastrointestinal:

☐Abdominal Pain	☐Constipation	☐Diarrhea
☐Heartburn	☐Excessive Hunger	☐Excessive Thirst
☐Hepatitis	☐Nausea	☐Vomiting

Musculoskeletal:

☐Arthritis	☐Joint Pain	☐Gout
☐Back Problems	☐Deformities	☐Joint Stiffness
☐Muscle Cramps	☐Muscle Stiffness	☐Paralysis
☐Restricted Motion	☐Weakness	

Skin:

☐Eczema	☐Itching	☐Easy Bruisability
☐Hives	☐Lumps	☐Skin Color Change

Neurological:

☐Loss of Consciousness	☐Blackouts	☐Burning
☐Dizziness	☐Fainting	☐Head Injury
☐Headaches	☐Numbness	☐Paralysis
☐Strokes	☐Tingling	☐Unsteady Gait

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

HEIGHT:_____ **WEIGHT:**_____

Allergies: List all Allergies and known reactions. ☐ I do not have any Allergies.

Current Medications: List all Medications with dosage ☐ I do not take any Medications.

☐ I give consent for my physician to view/request my prescription history _____
Initials

Family History: Specify the family member with any of the following applicable medical histories

Has any relative ever had:	Specify Family Member	Specify Maternal or Paternal and Living or deceased
Arthritis at an Early Age		
Bleeding Problems		
Cancer (Type:)		
Congestive Heart Failure		
Diabetes		
Gout		
Hypertension/High BP		
Scoliosis		
Stroke		
Tuberculosis		
Other:_____		

Your Medical History:

Social History:

Do you smoke tobacco? ☐Never smoked ☐Former smoker ☐Current some day smoker ☐Current every day smoker

How often do you consume alcoholic beverages? ☐Never ☐Rarely ☐Moderately ☐Daily

What is your Occupation? _____ Are you in School? ☐Yes ☐No

If in school, what is the school's name? _____What year of school are you in?_____

How many hours per week do you exercise? _____ Sports played during the year_____

If under 18, with whom do you live? _____

Gynecological (If Applicable):

Age first period started? _____ How long do periods usually last? _____ Frequency of periods? _____

Date of your last period? _____

Surgical History: List any past Surgeries

Clinician Notes: _____