NORTHERN KENTUCKY PEDIATRIC GROUP

We are so happy you have selected Northern Kentucky Pediatric Group to care for your child(ren)!

Contact Information

Address: 1016 Town Drive
Wilder, KY 41076

Phone: (859) 441-7600
Fax: (859) 441-7144

Website: www.nkypg.com

We are also on Facebook!

WE WANT TO BE YOUR CHILD(REN)'S MEDICAL HOME

A Medical Home seeks to improve the quality, effectiveness and efficiency of care while responding to each patient's unique needs and preferences. It is not a place but a process for building and maintaining a collaborative relationship between your child and our pediatric care team.

Here are just a few of the benefits of being part of a Medical Home:

Accessibility

Our phones are on Monday – Friday 7:30 – 5:00 and on Saturday from 8am – noon. We have a nurse triage available during these hours.

After Hours Access

After hours, a doctor and/or nurse practitioner are always on call. You may call our office and you will be connected to our answering service. The answering service will contact the provider on call. After 9pm the calls will go to a nurse triage line.

Appointments

We have same day appointments. Well child checks and behavioral health appointments should be scheduled in advance whenever possible so that we are prepared for your visit.

Primary Care Provider

Our providers deliver evidence-based care. We recommend you select a primary care provider within our office. We will try to schedule you with your selected provider whenever possible. You can change your PCP at ay time and can make an appointment to see any of our providers.

Vaccinations & Well Checks

We follow the Center for Disease Control and AAP recommendations for vaccinations and preventative health care. We FIRMLY believe all children should be vaccinated according to CDC recommendations. Our website has a complete listing of ages and immunizations (www.nkypg.com).

Services

Our office provides newborn care, well child checks, immunizations, and sports physicals. We also provide behavioral health, acute and chronic care. All our physicians see newborns at St. Elizabeth and Dr. Pappas also goes to Christ Hospital and Good Samaritan.

NORTHERN KENTUCKY PEDIATRIC GROUP

Resources
We offer a variety of resources on our website (www.nkypg.com) for multiple topics ranging from developmental milestones to allergies, substance abuse and oral health and many more! In addition to our website, we have many handouts in the office that correlate to these topics.

In order for us to provide you and your child(ren) with the best possible care, we need your help. Here is what we ask of you:

Prescriptions
We request that you allow 4 business days for controlled substance refills. When you call for the refill, please be prepared to provide the child's name, DOB, medication name, strength, and dosage.

For non-controlled substance prescription refills, have your pharmacy contact our office.

Insurance and billing
All copayments are due at time of service. All balances are due 10 days from the statement date. We accept payment via mail, in person, over the phone and on our website.

First Appointment
Please bring the following items to your first appointment:

- Current insurance card
- Completed New Patient Packet: demographic, insurance, reminder calls, general policies, HIPAA policy, child's medical history, and the social/family history forms. All these forms are available on our website.
- Copay

Please note, for patients transferring in to our practice, we will need the prior medical records in the office before we can schedule your first appointment. There is a medical records release form on the website for your convenience.

Information
It is your responsibility to keep us up to date with any changes including:

- Visits outside of our office, including (but not limited to) emergency department visits, urgent care visits, retail based-clinic visits
- Recent tests
- Changes in your child's health
- Medication changes including over the counter remedies and supplements
- Family history
- Insurance information

NORTHERN KENTUCKY
PEDIATRIC GROUP

PREFERRED CONTACT METHOD FOR REMINDERS

Please let us know how you would like to be contacted for REMINDERS:

PHONE **(by call)**: _____

PHONE **(by text message)**: _____

E-MAIL:_____

Please list the children in our practice so we can attach this request to all of your children.

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

**If there are additional children (more than 5) please be sure to list them as well.

_____ _____ _____

Signature Print Name Date

NORTHERN KENTUCKY
PEDIATRIC GROUP

Today's Date: _____

Child's Name: First _____ Last _____ **Date of Birth** _____

Child's Name: First _____ Last _____ **Date of Birth** _____

Child's Name: First _____ Last _____ **Date of Birth** _____

Child's Name: First _____ Last _____ **Date of Birth** _____

Address of Child's (Children's) Primary Residence:

_____ **City:** _____ **State:** ____ **Zip Code** _____

TELEPHONE NUMBERS			
• **Primary phone** (#1) is the one to be used first for messages and reminder calls. This does not have to be the home phone.			
• Please list phone numbers in the order to be called			
1. ( )	☐Home ☐Cell ☐Work ☐Other/Ext.	☐Mother ☐Father ☐ Other: Name ☐ Patient	Relationship:
2. ( )	☐Home ☐Cell ☐Work ☐Other/Ext	☐Mother ☐Father ☐ Other: Name ☐ Patient	Relationship:
3. ( )	☐Home ☐Cell ☐Work ☐Other/Ext	☐Mother ☐Father ☐ Other: Name ☐ Patient	Relationship:
4. ( )	☐Home ☐Cell ☐Work ☐Other/Ext	☐Mother ☐Father ☐ Other: Name ☐ Patient	Relationship:
By providing us with your wireless or land line phone number, you are giving us your prior express consent to call those numbers for business purposes.			

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION			
Parent 1 Full Name:		**Date of Birth:**	
Social Security #	**Relationship:** ☐ Mother ☐Father ☐ Legal Guard. ☐Step Dad/Mom ☐Self		
Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Remarried ☐Widowed			
Address: ☐Same as Child or	City	State	Zip
Employer:	Phone: ( )		Ext.
Occupation:	Email:	@	

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION			
Parent 2 Full Name:		**Date of Birth:**	
Social Security #	**Relationship:** ☐ Mother ☐Father ☐ Legal Guard. ☐Step Dad/Mom ☐Self		
Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Remarried ☐Widowed			
Address: ☐Same as Child or	City	State	Zip
Employer:	Phone: ( )		Ext.
Occupation:	Email:	@	

Step parents' name(s), if applicable:		
Custodial parent, if applicable:		
EMERGENCY/ALTERNATIVE CONTACT		
Full Name:	Relationship:	Phone: ( )

Parent/Guardian Signature: _____ Date: _____

How did you hear about us? _____

NORTHERN KENTUCKY PEDIATRIC GROUP

Insurance Information

FINANCIAL RESPONSIBILITY

Invoices/Statements should be mailed to: ☐Mother ☐Father ☐ Self ☐ Other:

Primary Insurance

Cardholder's Full Name: First _____ Last _____
Social Security _____ Date of Birth _____ Relationship to patient _____
Address (if different than child's): _____
City _____ State _____ Zip _____
Phone _____ Work _____
Employer _____ Business Phone _____
Employer Address _____ City/State _____ Zip _____
Insurance Company _____ ID # _____ Group# _____
Effective Date of insurance _____

Secondary Insurance

Cardholder's Full Name: First _____ Last _____
Social Security _____ Date of Birth _____ Relationship to patient _____
Address (if different than child's): _____
City _____ State _____ Zip _____
Phone _____ Work _____
Employer _____ Business Phone _____
Employer Address _____ City/State _____ Zip _____
Insurance Company _____ ID # _____ Group# _____
Effective Date of insurance _____

AUTHORIZATION FOR MEDICAL CARE FOR PATIENTS UNDER THE AGE OF 18

I (We) _____ and _____ authorize the Northern Kentucky Pediatric Group, LLC and its personnel to deliver services to my child(ren).

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence.**
This also allows the following people to pick up prescriptions, shot records & receive test results.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any other type of documents to be picked up by someone other than the legal guardians listed above must have written consent.

I (We) understand that telephone triage and advice services will ***not*** be extended to the above persons unless it is regarding direct patient care while the child is *in their care*. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If, however, we cannot reach you, we will ***not*** refuse to treat your child. This serves as consent for medical treatment that we deem as medically necessary and appropriate.

_____ _____ _____
Signature of Legal Guardian Date Relationship to patient

NORTHERN KENTUCKY
PEDIATRIC GROUP

GENERAL POLICIES AND FEES

PAYMENTS AND INSURANCE AUTHORIZATION/ASSIGNMENT OF BENEFITS

Co-pays, as well as past due balances, shall be collected from the party here with the minor child at the time of appointment. This payment is required regardless of who brings the child in to be seen. We understand that issues related to divorce are difficult for the whole family, however, we will not be party to custodial, separation or financial disputes between parents. We maintain that these issues should not affect the medical care of the child; such matters should remain between the parents. Both parents have access to the minor child's medical records unless we are provided with a court order that mandates otherwise.

I must have proof of insurance at every appointment or I will have to pay in full to be seen. If I have an insurance change, I understand that it is my responsibility to verify that the office accepts my child's new insurance, prior to being seen. If I have a newborn, I must present proof of application by the 30 day mark if I do not have my baby's proof of insurance by then. The only Medicaid the office accepts is Aetna Better Health.

I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/copays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.

I understand that bad checks are subject to a $30 charge from our office, as well as the balance of the bounced check. Failure to pay the check and all fees could result in being sent to the County Attorney. Once sent to the County Attorney, the fee increases to $100.00 + the cost of the check, and possible arrest and criminal prosecution.

I understand that I risk dismissal for noncompliance with payment plans and/or failure to keep my balance current.

Should I need to cancel an appointment I understand that I must call the office in a timely manner, so the appointment time can be utilized by another patient. I understand if I no show multiple appointments I also risk dismissal from the practice.

I understand that well and sick benefits may be handled differently by my insurance company, and if during a well visit, my child is sick, or has an issue needing treatment and/or medical attention, my provider may bill for both services. Regardless of what the well visit benefits are, I will be responsible for any charges my insurance passes on to me for the sick visit portion. In this case, the sick visit copay is due and will be collected at the time of my visit. I hereby grant permission to the Northern Kentucky Pediatric Group, LLC to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to the Northern Kentucky Pediatric Group, PSC. A photocopy of this authorization shall be considered as valid as the original.

I have read and understood the above. I am aware I can request a copy for myself at any time from the front office.

_____	_____	_____
Signature of Parent / Legal Guardian (child must be under 18 years old)	**Today's date**	**Relationship to patient**

We are a Medical Home! Please visit our website for additional information, www.nkypg.com

Please visit our Facebook page as well. Search "Northern Kentucky Pediatric Group"

NORTHERN KENTUCKY PEDIATRIC GROUP

HIPAA NOTICE OF PRIVACY POLICIES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOU MUST SIGN THE REVERSE SIDE OF THIS DOCUMENT

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our web site.

I have read and understood the above. I am aware that I may ask for a copy of the Notice of Privacy Policies at any time from the front office.

Signature of Parent / Legal Guardian *(PATIENT IF 18 OR OLDER)*	Relationship to the patient	Today's Date

EFFECTIVE 10/2017

NORTHERN KENTUCKY PEDIATRIC GROUP

Child's Name _____
Your Name _____
Date _____
Relationship to child _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is this child yours by ☐ birth ☐ adoption ☐ stepchild ☐ other
Pregnancy complications _____
Delivery by ☐ vaginal ☐ c-section
Reason for c-section _____
Complications _____
Was your child premature? ☐ No ☐Yes, born at _____ weeks
Complications _____
Birth weight _____ Length _____
Problems in the newborn period ☐ Jaundice ☐Infection
☐ Other _____

Infancy/Childhood/Adolescence

Are your child's immunizations up-to-date? ☐ Yes ☐ No
Has your child ever been treated for or diagnosed with: (explain)

☐ Asthma or reactive airway disease _____
☐ Wheezing or bronchiolitis _____
☐ Seasonal allergies or eczema _____
☐Food allergy _____
☐ Recurrent ear infections _____
☐ Pneumonia _____
☐ Urinary tract infections _____
☐ Genetic syndrome _____
☐ Seizures _____
☐ Broken bone(s) _____
☐ Developmental delay/Learning problem_____
☐ Depression/Anxiety _____

Other health problem(s) _____
_____
Has your child ever been hospitalized? ☐ No ☐ Yes, explain:
_____
_____
Previous surgeries with dates: _____
_____
Please list any specialist your child has ever seen and why:
_____
_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____
Current medication(s) and dose: _____
_____
_____
☐Vitamins ☐ Supplements _____
☐ Over-the-counter _____

Development/Nutrition

At what age did your child
Walk alone _____
Toilet train (day) _____
Sit alone _____
say words _____
1st Period _____
Was your child breastfed? ☐No ☐ Yes, how long_____
Has your child had any feeding/dietary problems? Explain:
_____
Current milk intake: Type: _____ Amount: _____oz/day

Review of Systems Check all that your child has had recently

Constitutional
☐ Fever, chills ☐ Unexplained weight loss/gain
☐ Fatigue ☐ Excessive thirst

Ears, Nose and Throat
☐Hearing problem ☐Ear pain
☐Mouth breathing ☐Frequent runny nose
☐Snoring

Gastrointestinal
☐Abdominal pain ☐Nausea, vomiting, diarrhea
☐Constipation ☐Blood in stool

Respiratory
☐Cough ☐ Shortness of breath
☐Chest tightness ☐Wheeze

Cardiovascular
☐Chest pain ☐Palpitations
☐Fainting ☐Tires easily with exertion

Genitourinary
☐Frequent/painful urination
☐Bedwetting, frequent accidents
☐Vaginal/penile discharge

Musculoskeletal
☐ Joint pain ☐Joint swelling
☐Muscle pain ☐Muscle weakness
☐Bone Pain

Neurological
☐Headaches ☐Seizures
☐Clumsiness ☐Milestone delay

Psychiatric/Emotional
☐Anxiety/stress ☐Depression
☐Sleep Problem ☐Anger concerns
☐Concerns with attention, impulsivity

Other
☐Blurry vision ☐Squinting
☐"Crossed" eyes ☐Itchy eyes
☐Rashes ☐Abnormal moles
☐ Abnormal bruising/bleeding

Reviewed by: _____

Date: _____

NORTHERN KENTUCKY PEDIATRIC GROUP

Child's Name _____
Your Name _____
Date _____
Relationship to child _____

Social History

Parents are ☐Married ☐Unmarried ☐Divorced ☐Other _____
Who lives in the household with the child? ☐ Mom ☐Dad ☐ Siblings # _____ ☐Grandparent ☐ Other _____
Childcare: ☐Parent ☐Relative ☐Daycare ☐Sitter/Nanny Days per week in childcare/not with parent _____
Do any household members smoke? ☐Yes ☐No
How many hours per day does your child spend: Watching TV _____ Computer_____ Video Games _____
Child's school name: _____
Any concerns about school performance? ☐ No ☐Yes, explain: _____
Any concerns about peer or teacher relationships? ☐ No ☐Yes_____
Sports/Exercise type: _____ How often? _____ How long? _____ min.
In the past year, have you or any family member living with you had any problems with the following: ☐Food ☐transportation ☐medical care ☐utilities (gas or electric)

Family History

Please check the conditions that any of the child's **blood relatives** have and state their relationship to the child as well as on whose side they come from (mom vs. dad). So as an example: If mom's mom has/had a disease, write M-Grandmother. If dad's mom has/had a disease, write D-Grandmother.

Condition	Mother	Father	Sibling	Grandparent
Allergies				
Eye or Ear disorder				
Genetic/Birth defects				
Arthritis				
Heart disease/Heart attack/Heart Problems				
High cholesterol				
High Blood Pressure				
Blood or Bleeding problems				
Stroke				
Liver disease/hepatitis				
Renal/Kidney disease				
Asthma				
Lung disease				
Tuberculosis				
Bone/joint disorders				
Muscle/Nerve disorder				
Eczema/Skin condition				
HIV/AIDS				
Thyroid/Hormone disorder				
Diabetes				
Cancer				
Mental/Psychiatric disorder				
Developmental delay/Learning problems				
Addiction to drugs/alcohol				
ADHD/ADD				
Migraines				
Sickle Cell Anemia				
Other				

Have any children in your family died? _____ If yes, please explain how: _____

Please use the back of this sheet to describe anything else you would like us to know. Thank you.

Signature of Parent or Legal Guardian: _____