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Lactation Registration

Mom: Last Name: _____ **First Name:** _____ **MI:** ____

Preferred Name: _____

DOB: _____ **Preferred Language:** _____

Ethnicity: **Race:**

Cell #: _____ **Home #:** _____

Work #: _____ **Email:** _____

Address: _____

_____

Baby: Last Name: _____ **First Name:** _____ **MI:** ____

Preferred Name: _____ **DOB:** _____ **Sex:** ☐ M/ ☐ F

Ethnicity: **Race:**

Mom Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Sex: ☐ M/ ☐ F

Relationship to patient: _____

Insurance Carrier: _____

ID#: _____ Group#: _____

Baby Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Sex: ☐ M/ ☐ F

Relationship to patient: _____

Insurance Carrier: _____

ID#: _____ Group#: _____

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MOTHER'S MEDICAL HISTORY FORM

Your answers on this form will help your provider understand your child's medical history.

BIRTH HISTORY:

Medical Problems during pregnancy _____

Medications during pregnancy (including SSRI, Anticonvulsants, herbal, vitamins):

_____

Delivery ☐ Normal Vaginal Delivery ☐ Elective C-section ☐ Emergent C-section ☐ Forceps/Vacuum

Spontaneous / Induction (Circle One)

GBS + / -

IV Fluids: Y / N If yes, how long? _____

Epidural Administered: Y / N If yes, how long? _____

Pitocin: Y / N

Location of Delivery: _____ **Attendant:** _____

Number of weeks gestation _____

Significant Delivery Circumstances: _____

Problems during the newborn period _____

MATERNAL HISTORY:

MEDICATIONS:

Medication (Prescription/Herbal/Natural/OTC)	Dose	How Many Times per day

ALLERGIES: ☐ No ☐ Yes If yes, what is the allergy and what was the reaction?

_____

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PAST MEDICAL HISTORY

- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Chromosomal Anomalies
- ☐ Concussion
- ☐ Constipation
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine (thyroid)
- ☐ Fertility Concerns
- ☐ Handicaps/Disabilities
- ☐ Headaches
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ Immunodeficiency
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Psoriasis
- ☐ Seizures
- ☐ Urinary Tract Infections
- ☐ Vision Problems
- ☐ Other _____

HOSPITALIZATIONS (when and why)**:**

_____

SURGERIES (when and why, including breast surgery)**:**

_____

Previous Breastfeeding Experience: _____

MENSTRUAL HISTORY:

Age of first period _____ years Have Menses Returned? If so, when _____

Were cycles regular before pregnancy? Yes / No

FAMILY HISTORY: _____

SOCIAL HISTORY:

Smoking: _____ # of packs per day

Alcohol: _____# per day / week (Circle One)

Recreational Drug use: _____

Location of Baby for sleep: _____

Any pets? _____

PRIMARY CONCERNS:

_____

_____

_____

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Office Policy for Lactation Care

Please initial on each line

_____ **Appointments will be provided in a timely manner**

All routine new and established patients are accommodated within five days; all urgent appointments for established patients will be attempted to be scheduled on a same-day or next-day basis.

_____ **Mutual Respect of Time**

We pride ourselves on punctuality at One Family Pediatrics. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We may have to reschedule or squeeze you in whenever there is space if you arrive more than 15 minutes late.

2. If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time with you.

3. We will provide you with all of the time that you need, but you must tell us when making the appointment ALL of the reasons you would like to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.

4. If you are running late, call the office. We may be able to accommodate you with advanced notice.

_____ **No Show and Same Day Cancelation**

Infant feeding problems are considered acute care and need to be seen as quickly as possible. Failing to show up for appointments impedes progress in reaching your feeding goals. After two no-shows or same day cancelations, you will be given same-day appointments only. No-showing to a same day appointment will result in discharge from the practice. You will be seen for emergency care only for 30 days after discharge. We will provide a list of other lactation care providers who may better serve your needs. No-shows will result in $75 charge.

_____ **Payment is required at the time services are rendered**

This includes applicable coinsurance, co-payments and payments for services not covered or denied by the insurance company.

_____ **Self-pay accounts**

If you do not have insurance, please come prepared to pay for your visit in full. We offer a 30% discount for all self-pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a budget agreement can be made to have the service paid within 90 days with the first payment payable the day the service is rendered.

_____ **Copays**

We are required by our insurance contracts to collect all co-payments at the time of service. Failure to collect co-payments puts the responsible party and One Family Pediatrics in default of the insurance contract.

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_____ **Missed Appointment Fee**

Broken appointments represent a cost to us, you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of $75 and may result in dismissal from the practice. This fee must be paid before a new appointment is scheduled. Patients with ***three*** missed appointments in a twelve-month period will be asked to transfer their records to another practice. Your child's appointment time will be confirmed via an automated email, phone or text. If you do not confirm the appointment within 24 hours, we will cancel your appointment and request that you reschedule to a later time.

_____ **Credit Card on File Policy for Commercial Insurance**

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. As a result, we require that all patients need to have a credit or debit card number on file with our office. Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

I have read the Office Policy as outlined above and understand the consequences. I also understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

One Family Pediatrics accepts cash, debit cards, HSA cards, Visa, Master Card, Discover and American Express.

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency, the undersigned shall pay all collection agency fees, court costs and attorney fees, and risks being dismissed from the physician care of One Family Pediatrics.

By my signature below, I authorize the release of information necessary to file a claim(s) with my insurance company (ies) and assign benefits otherwise payable to me, to the provider, or the group indicated on the claim. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the full payment or balance as allowed on my account. I understand that co-payments, deductibles and payments for services not covered or denied by the insurance company are due at the time of service. I understand that if my account goes to collections, I shall pay all collection fees and costs incurred by One Family Pediatrics. I certify that this information is true and accurate to the best of my knowledge and will notify the office of any changes to my information, such as, but not limited to change in address, telephone numbers, insurance coverage, custodial relationships, etc. I have read, understand, and agree to abide by the Financial Policy.

Name of Patient(s):_____

Guarantor Name: _____

Guarantor's Signature: _____ Date: _____ /_____ / _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CREDIT CARD ON FILE POLICY

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement that explain how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Credit Card on File Policy, Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement. Copies are available on our website, in the waiting room, and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices, Privacy Policy Statement or Security Policy Statement or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that One Family Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement, which describes how medical information about me may be used and/or disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: **HIPAA Compliance Officer Dr. Hiral Lavania at (678) 962-7337.** I also understand that I am entitled to receive updates upon request if One Family Pediatrics amends or changes its Notice of Privacy Practices, Privacy Policy Statement or Security Policy Statement in a material way.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient/patient's representative Relationship to patient

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For OFFICE USE ONLY

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices, Privacy Policy and Security Policy from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (Specify): _____

_____ _____ _____

Name and Title of Employee Signature Date