PEDIATRIC PATIENT REGISTRATION

(Please Print)

MICHAEL J. O'NEILL M.D., PLLC
240 Beacon Lite Road
Monument, Colorado 80132
Phone: 719-419-7490
Fax: 719-309-6847

Date: ______________________________

Patient: ______________________________
(Last Name, First Name, Middle Initial)

SSN: ______________ Male: ____ Female: ____

Date of Birth: ______________________________

Street Address/P.O. Box: ______________________________

City: ______________ State: ______________ ZIP Code: ______________

Home Phone: ______________ Cell Phone: ______________

Parent/Guardian information

Mother ______________________________ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: ______________________________

City: ______________ State: ______________ ZIP Code: ______________

Home Phone: ______________ Cell Phone: ______________

Occupation: ______________ Employer: ______________

Business Phone: ______________ City: ______________ State: ______________ ZIP Code: ______________

Father ______________________________ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: ______________________________

City: ______________ State: ______________ ZIP Code: ______________

Home Phone: ______________ Cell Phone: ______________

Occupation: ______________ Employer: ______________

Business Phone: ______________ City: ______________ State: ______________ ZIP Code: ______________

*If mother & father are not living together or if the child does not live with the parents, what is the child's custody status?

____

In Case of Emergency, Please Contact:

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Persons Authorized to Accompany and Provide Consent for Treatment Other Than Parents:

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Preferred Pharmacy Name:

Location: ______________________________ Phone: ______________________________

Please List All Persons Living in the Child's Home:

Name	Relationship to Child	Date of Birth

Are there siblings not listed? If so, Please list their names, ages and where they live: ______________________

____

____

Name of Insured/Responsible Party: ______________________

Relationship to Patient: ____________ SSN: ______________________ Date of Birth: ______________

Home Phone: ______________________ Cell Phone: ______________________

Street Address/P.O. Box: ______________________

City: ______________ State: ______________ Zip: ______________

Name of Primary Insurer: ______________________

Contact #: ______________ Group #: ______________ Subscriber #: ______________

Name of Secondary Insurer: ______________________

Contact #: ______________ Group #: ______________ Subscriber #: ______________

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Michael O'Neill M.D., LLC. to release any pertinent information to my insurance company upon request and I also authorize payment directly to Michael O'Neill M.D., LLC.

A photocopy of this authorization shall be considered as effective and valid as the original.

______________________ ______________________

Signature of Parent/Guardian Date

______________________ ______________________

Signature of Witness Date

lichael J. O'Neill, MD,PLLC

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PEDIATRIC HEALTH HISTORY FORM

BIRTH HISTORY:

Where was your child born? _______________ Is child yours by (circle): Birth/Adoption/Stepchild/Other

Delivery (circle): Vaginal/C-Section/Vacuum/Forcep If C-Section, reason for C-section: _______________

Was your child premature? Y/N If yes, born at how many weeks? _______ Birth Weight: __________ Birth Length: __________

Complications during this pregnancy or delivery? _______________

Bilirubin/Jaundice (level at birth) _____ Was your baby in the NICU? Y/N If yes, reason _______________ How long? _____

Other problems in the newborn period _______________

INFANCY/CHILDHOOD/ADOLESCENCE:

Please list ALL of your child's medical hospitalizations/diagnoses/surgeries, dates of diagnoses and treatment

Diagnosis/Surgery/Hospitalization:	Date	Treatment
1.		
2.		
3.		
4.		
5.		

Specialist(s) your child is currently seeing and reason: _______________

Medications: Please list ALL of your child's current medications (please include any vitamins, herbal supplements, OTC meds)

Medication:	Dose:	How often?
1.		
2.		
3.		
4.		
5.		

Allergies: Please list ALL allergies (medication, food, seasonal) & describe reaction:

____

Development: At what age did your child: walk alone ____ Sit alone ____ Toilet train (day) ____ Say words ____ 1st period (females) ____

Nutrition: Was you child breastfed? Y/N If yes, how long? ____ Current milk intake: Type __________ Amount ________ oz/day

Has your child had any unusual feeding/dietary problems? If yes, please explain _______________

FAMILY HISTORY:

Medical Condition:	Mother:	Father:	Sibling:	Grandparent:
Asthma				
Anemia				
Blood disorder				
Cancer (specify type)				
Heart attack/disease				
High cholesterol				
Stroke				
Diabetes (Type I or Type II)				
Thyroid disease				
Kidney disease				
Seizures				
Depression/Anxiety				
Alcoholism				
ADD/ADHD				
Other:				

MICHAEL J. O'NEILL, MD, PLLC

PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Michael J. O'Neill ,MD,PLLC patient

Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen **Michael J. O'Neill,MD,PLLC** as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Michael J. O'Neill, MD,PLLC permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and **Michael J. O'Neill,MD,PLLC** is not your PCP, you may be responsible for deductibles, co-insurance. and other non-covered services.
- If your plan requires referrals from **Michael J. O'Neill,MD,PLLC** to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

Financial Obligations

1. Co-payments are due at the time of service.
2. Michael J. O'Neill, MD will bill participating insurance companies after verifying coverage. If claims are not paid, Michael J. O'Neill, MDwill bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Michael J.O'Neill, MD the payment must be forwarded to us. You may issue a personal check toMichael J. O'Neill, MD Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance thatMichael J. O'Neill, MD participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Michael J. O'Neill, MD bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:

Patient/Guardian:______________________________ Date:______________

Witness:______________________________ Date:______________

A copy of this form is available upon request.

Michael J. O'Neill, M.D., PLLC
Family Practice
www.michaeloneillmd.com

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Fax: 719-309-6847

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CONSENT NOTICE

*** PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Michael J. O'Neill M.D. and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Michael J. O'Neill M.D., PLLC. is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Michael J. O'Neill M.D., PLLC. reserves their rights to amend their Notice of Privacy Practices from time to time and that I may at any point request a copy of the current Notice at the address listed above.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent must be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

____
Signature of Patient/Personal Representative

____
Date (MM/DD/YYYY)

____
Printed Name

Michael J. O'Neill, M.D., PLLC
Family Practice
www.michaeloneillmd.com

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HIPAA NOTICE OF PRIVACY PRACTICES

Health Information Covered By This Notice
Personal health information or health information is information we create or receive that identifies you and relates your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for health care furnished to you.

Our Pledge Regarding Health Information
We understand that health information about you is personal. We are committed to protecting the privacy of your health information by complying with all applicable federal and state privacy and confidentiality laws. We are required by law to maintain the privacy of your health information and to provide you with this Notice about the ways in which we may use and disclose health information about you, our legal obligations and privacy practices and your privacy rights.

How We May Use and Disclose Health Information About You
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we explain what we mean and give an example. Not every use of disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information under federal law will fall within one of the categories. Except in certain limited cases such as emergencies, we are required to obtain your written consent prior to releasing your medical records to another party.

Treatment
We may use health information about you to provide you with health treatment or services. We may disclose health information about you to physicians, nurses, technicians, medical students or other personnel who are involved in taking care of you. This facility may share health information about you for care coordination, such as prescriptions, lab work and x-rays. We also may disclose health information about you to a specialist who is consulted about your treatment or care. It is also our practice to provide information about the care and treatment we provide to you referring physician of record so that he or she has appropriate information for providing future care to you.

Payment
We may use and disclose health information about you in order to obtain payment for services. For example, we may provide your health plan with information about services you received so your health plan will pay us or reimburse you for the clinic visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment

Michael J. O'Neill, MD,PLLC

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AUTHORIZATION TO RELEASE PEDIATRIC HEALTH CARE INFORMATION

This release expires 1 year from the date of signature or upon written request

Patient Name: ______________________________

Last First MI

Date of Birth: ____________________ **SSN:** ____________________

Current Address: ______________________________

Street Apt # City/State Zip Code

If moving, new address: ______________________________

Street Apt # City/State Zip Code

Primary Phone: ______________________________

I SPECIFICALLY AUTHORIZE: (PRIOR Health Care or Mental Health Care provider)

Name of Doctor/Facility: ______________________________

Doctor/Facility Address: ______________________________

Street Apt # City/State Zip Code

TO RELEASE, SEND, AND/OR DISCUSS ALL OR PART OF MY MEDICAL RECORDS, AS DESCRIBED ON THIS FORM, FOR THE REASON OF CONTINUITY OF CARE. Please mark all that apply:

_____ All records generated by past provider _____ Immunization Records Only _____ Mental Health Diagnosis

_____ Mental health therapies and status _____ Prior labs, imaging, test results _____ Care Coordination

_____ Other: ______________________________

PLEASE RELEASE MY RECORDS TO: Michael J. O'Neill, MD, PLLC
240 Beacon Lite Road
Monument, Colorado 80132

Patient Signature (if 18 yrs or older): ____________________ **Date:** __________

OR

Signature of Legal Representative: ____________________ **Date:** __________

FOR SENSATIVE INFORMATION: I understand that this separate consent is required to release sensitive healthcare information in my record, and I specifically request that you release any information in my records pertaining to discussion, testing, diagnosis, or treatment regarding sexual activity, reproduction, birth control, sexual or reproductive related disease(s), and addiction to or use of drugs and alcohol.

Patient Signature (if 18 yrs or older): ____________________ **Date:** __________

OR

Signature of Legal Representative: ____________________ **Date:** __________