❒ New Patient
❒ Existing/Update

CHILDREN'S HEART INSTITUTE

PEDIATRIC PATIENT REGISTRATION

Account No.

Patient Information

Child's Name: First Name – M I – Last Name	Nick Name	Birth Date	Sex	Soc. Sec #
			[] M [] F	

Mother (❒ Birth ❒Stepmother / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Mother?* **Yes / No**

Mother's Full Name (First M. Last)		Social Security Number		Date of Birth
Home Address		City	State	Zip
Mother's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Mother's Home E-mail	

Father (❒ Birth ❒Stepfather / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Father?* **Yes / No**

Father's Full Name (First M. Last)		Social Security Number		Date of Birth
Home Address		City	State	Zip
Father's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Father's Home E-mail	

Referring Physician – (Primary Care Physician)

Physician Name: Reason for Today's Visit:	

Primary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

Secondary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

I certify that the information I have reported above is correct and that as the Parent/Guardian/Guarantor I have read, understand and fully accept the Patient's Financial Payment Policy conditions of Registration.

Signature of Parent/Guardian/Guarantor _____ Print Name _____ Date _____

Please read and sign the *Practice Payment and Financial Policy* on the back of this form. *Thank You*

PATIENT HISTORY INTAKE – CARDIOLOGY / CARDIOVASCULAR

(CHILD)

FEEDING HISTORY - (For Babies / Infants Only)

1) If on formula, how many ounces at each feeding?
2) How long does it take the baby to finish one feeding?
3) If breast feeding, how many minutes on each breast?
4) Does the baby suck strongly during a feeding? ◯ Yes ◯ No
5) Does the baby get tired easily during feeding? ◯ Yes ◯ No
6) Does the baby sweat or have labored breathing during feeding? ◯ Yes ◯ No

SOCIAL HISTORY

Does the child live with both parents? ☐ Yes ☐ No – If No, Lives with:			
Mother Age?	Father Age?	Mother Job?	Father Job?
How many siblings does the child have?		Age/Sex of Sibling Each?	
Do any siblings also have Congenital or other heart disease? [] Yes [] No – If Yes, please detail:			
At what grade in school?		Any problems at school?	
What hobbies/activities does the child enjoy/play?		What kind of sport does the child participate in?	
Any major stress at home, or school?			

GROWTH AND DEVELOPMENT

Does child appear to be growing similar to family pattern? ☐ Yes ☐ No
Does child have any difficulty keeping up with age group? [] Yes [] No; If yes, please describe below
Is the child up to expectations at school? Any learning or attention problems? [] Yes [] No; If yes, please describe.

PAST MEDICAL AND SURGICAL HISTORY

Prescription & OTC Drugs - Name / Dosage / Frequency		***Any Drug or Food Allergies?*** ☐ Yes ☐ No ☐ Not Known	
		List Drug or Food:	
Operations / Hospitalizations – Reason	***Date***	***Operations / Hospitalizations – Reason***	***Date***

PATIENT'S PAST MEDICAL AND FAMILY HISTORY

PLEASE INDICATE IF YOU OR A RELATIVE - (M) =MOTHER / (F) =FATHER / (S) =SIBLING / (GP) =GRAND PARENT – WAS AFFECTED BY CONDITION

Condition	***You***	***Relatives***	***Condition***	***You***	***Relatives***
Anemia			High Cholesterol or Triglycerides		
Blood Clot or Bleeding Disorder			Kawasaki Disease		
Congenital Heart Disease (Born With)			Mitral Valve Prolapse		
Deaf from Birth (Neuronal)			Rheumatic Fever		
Diabetes - [] Type I [] Type II			Stroke or Mini-strokes (TIA)		
Heart Murmur			Unexplained death in young		
Heart Attack / MI			Thyroid Problems		
High Blood Pressure			Other Cardio-Vascular Disease		

REVIEW OF SYSTEMS HISTORY - **DOES YOUR CHILD HAVE ANY OF THE FOLLOWING SIGNS AND/OR SYMPTOMS? (CHILD)**

PLEASE MARK (X) IF ANY OF THE FOLLOWING APPLY TO YOU **CURRENTLY**, IN THE **PAST** OR **NEVER**

	CURRENTLY	PAST	NEVER	List Other Signs or Related-Symptoms
GENERAL HEALTH				
Healthy Appetite	☐	☐	☐	
Weight loss or Weight gain	☐	☐	☐	
Fever	☐	☐	☐	
Fever last over 5 days	☐	☐	☐	
Lethargy	☐	☐	☐	
Excessive Fatigue	☐	☐	☐	
EYES				
Vision changes	☐	☐	☐	
EARS, NOSE, THROAT & MOUTH				
Ringing in ears	☐	☐	☐	
Sinus problems or Sore throat	☐	☐	☐	
CARDIO / PERIPHERAL VASCULAR				
Chest Pain or discomfort	☐	☐	☐	
Irregular heart rhythms	☐	☐	☐	
Palpitations	☐	☐	☐	
Color changes in Lips or Tongue	☐	☐	☐	
Swelling around eyes, hands or Feet	☐	☐	☐	
RESPIRATORY				
Coughing or Wheezing	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Difficult breathing on exertion	☐	☐	☐	
Painful breathing	☐	☐	☐	
Rapid breathing	☐	☐	☐	
GASTROINTESTINAL				
Abdominal Pains	☐	☐	☐	
Nausea or Vomiting	☐	☐	☐	
Black or Bloody stool	☐	☐	☐	
Heartburn or Acid reflux	☐	☐	☐	
URINARY				
Blood in urine	☐	☐	☐	
Painful urination	☐	☐	☐	
MUSCULOSKELETAL				
Muscle aches / pains / weakness	☐	☐	☐	
Bone aches / pains / weakness	☐	☐	☐	
Swelling of legs	☐	☐	☐	
Pain in extremities	☐	☐	☐	
SKIN / BREAST				
Masses / Lumps or Rash / Ulcers	☐	☐	☐	
NEUROLOGICAL				
Dizziness	☐	☐	☐	
Fainting	☐	☐	☐	
Forgetfulness or Confusion	☐	☐	☐	
Headaches	☐	☐	☐	
Numbness	☐	☐	☐	
Seizures	☐	☐	☐	
PSYCHIATRIC				
Depression	☐	☐	☐	
Anxiety / Stress	☐	☐	☐	
ENDOCRINE				
Excessive Sweating	☐	☐	☐	
Thyroid problems	☐	☐	☐	
Abnormal thirst	☐	☐	☐	
HEMATOLOGIC / LYMPHATIC				
Bruises, frequent	☐	☐	☐	
Enlarged lymph nodes	☐	☐	☐	
Thyroid problems	☐	☐	☐	

Nurse Note:

Children's Heart Institute

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"NOTICES OF PRIVACY ACT"

Effective July 20, 2004

1. The Children's Heart Clinic may use and disclose protected health information for treatment, payment, health care operations and voluntary research operations. Examples of these include, but are not limited to, referrals to home health agencies and other providers for treatment. Payment examples include but are not limited to collection agencies, insurance companies for claims and pre-authorization, including coordination of benefits with other insurers. Health care operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. The Children's Heart Clinic is permitted or required to disclose protected health information without the individual's written consent in certain circumstances. Two examples of such are for public health requirements or court orders.
3. The Children's Heart Clinic will not make any other use or disclosure of a patient's protected health information without the individual's written authorization, which may be revoked at any time in writing.
4. The Children's Heart Clinic will abide by the terms of this notice currently in effect at the time of the disclosure.
5. The Children's Heart Clinic reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Any revisions will be posted and copies may be obtained at any time at our office.
6. Any patient, guardian, or personal representative has the right to inspect and obtain copies of their medical records. A fee will be assessed for copies.
7. Any patient, guardian, or personal representative has the right to request amendments to be made to their medical record.
8. Any patient, guardian, or personal representative has the right to request a six-year accounting of all disclosures of their medical records from April 2003 henceforth. The history will be provided within 60 days of the request and a reasonable charge will be assessed for any copies after the first requested in a 12 month period.
9. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to the restriction requested in a 12 month period.
10. Any person or patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy has been violated. To file a complaint with the practice, please contact the privacy officer at The Children's Heart Clinic at 540-310-0117. It is the policy of this practice that no retaliatory action will be made against any individual that submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
11. A detailed copy of this Notice of Privacy Act is available upon request.

NAME OF PATIENT:_____ DATE:_____

SIGNATURE OF PATIENT OR GUARDIAN:_____

Children's Heart Institute Practice Financial Policies

1. **Patient Information/Proof of Insurance:**
   At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for payment of services rendered.
2. **Insurance**: We participate in most insurance plans. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, 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 and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.
3. **Referrals:** Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full.
4. **Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Deductibles are due at the time of notification by your insurance company.
5. **Non-covered services**: Not all services provided by our practice are covered by every plan. Any service determined to not be covered by your plan will be your responsibility, Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid. The charges for these non-covered services be your responsibility and must be paid before being scheduled for another appointment.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.
7. **Claims submission:** Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. 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
8. **Nonpayment/delinquent accounts:** If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full to halt collection activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and processing costs.
9. **Missed appointments:** Our policy is to charge for missed appointments not canceled within 48 hours of your scheduled appointment. These charges will be your responsibility and must be paid before being scheduled for another appointment. The charge for missed appointments for patients with POTS or Stress Test is $100, for all other conditions it is $50.
10. **Forms Fees:** Any forms such as school, camp, sports, family and medical forms are subject to a fee that is due when the forms are dropped off. Completing these forms is time consuming to our staff, and requires time away from patient care from our providers. The charge for the form is determined by the complexity of

the required written or verbal communication. Fee amount may periodically change without prior notice. Payment for these forms is nonrefundable. It is our duty that these forms are accurate and consistent with the patient care plan needs. We require 15-days turnaround time.

11. **Release of medical information**: You will be provided a copy of our policies at the time of your visit and required to sign a release that authorizes us to provide a copy of your medical records if requested by your insurance carrier to process a claim. This release will expire one year from the date of your signature unless cancelled in writing prior to that date.
12. **Contacting us concerning your Bill**: You may call our Billing director at 571 612 2600 or you may email us at billing@chiva.org with any billing questions or concerns. Our goal is to provide and maintain a good Physician-patient relationship focused on your clinical needs while letting the experts in our billing department handle their work directly. Please address all billing concerns with those experts rather than your physician so that your clinical team can focus on your medical care

13. **Termination of Services:** If you do not respond to 3 notices to the address we have on file, you agree that Children's Heart Institute PLC may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual our provider.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____