100 DEAN DRIVE
MT. ORAB, OH 45154
PHONE: (937) 444-0035 / FAX: (937) 444-0036

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **ALL ABOUT KIDS PEDIATRICS** to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: ALL ABOUT KIDS PEDIATRICS has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: **ALL ABOUT KIDS PEDIATRICS**
100 DEAN DRIVE
MT. ORAB, OH 45154

Phone: (937) 444-0035
Fax: (937) 444-0036

Acknowledgement and Consent

I have received the Notice of Privacy Practices for **ALL ABOUT KIDS PEDIATRICS** is authorized to use health information about for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Patient Name Date of Birth

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Relationship to Patient Date

IDENTITY OF RECIPENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Phone/Voice Message on phone number on file:
YES_____ NO_____

I give permission to bring/treat/disclose medical information regarding patient to the person(s) below:

_____

_____

Patient Consent

1. **CONSENT TO MEDICAL CARE AND TREATMENT**

My child is being treated at All About Kids Pediatrics, LLC, and I consent to all medical care, examinations and tests determined by my Physician that are necessary. Though I expect the care given will meet my customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my child's heath that the Physician and this Office will not be responsible for any injuries or damages that are the results of my non-compliance. I understand that if an employee or any individual associated with AAKP is exposed to my blood or body fluids, my child will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. **CONSENT TO USE OF INFORMATION**

Electronic Health Records. I understand that AAKP may collaborated with other health care providers to coordinate, manage and provide health care to my child and I consent to AAKP's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessibly by physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). AAKP has implemented administrative, physical, and technical safeguards that reasonably and appropriately project the confidentiality and integrity of my child's medical information as required by HIPAA.

Request for Information from Others. I consent to AAKP's request of my health information from other providers of care to my child, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as AAKP's participation in any health information exchange described in AAKP's Notice of Privacy Practices (NNP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information (HIPAA Consent)

Use and Disclosure of Information. In addition to the above consent to use and share my health information with Azalea EHR system, I agree that AAKP may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer , state and federal government programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

FLIP OVER AND COMPLETE BACKSIDE →

3. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of AAKP's Notice of Privacy Practices which provides information on how AAKP may use or disclose PHI for purposes of treatment, payment, or health care operations.

4. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to AAKP for services provided to my child. I understand that benefits may be payable to me directly if I do not provide this authorization.

5. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided, or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer. Exceptions include those patients who qualify for discounted fees per sliding fee schedule.

6. PERSONAL VALUABLES

I understand that AAKP does not accept responsibility for any lost, stolen, or damaged personal items while I am at AAKP.

Patient Name: _____ Date of Birth: _____

_____ Date: _____ _____

Patient or Legal Representative Signature Relationship of Legal Representative to Patient

Rev. 01/14/2026

Child's Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____Email address: _____

Guarantor(person responsible for account):_____Guarantor DOB:_____

Emergency Contact(someone other than Guarantor): _____

Relationship:_____ Emergency contact Phone Number: _____

How would you like to receive Appointment reminders? (Chose one option)

____ call ____ text ____email

Do we have permission to obtain your child's electronic vaccination records through Impact?

_____ yes _____no

Do we have permission to share your child's medical records with the local hospitals?

_____ yes _____no

Do we have permission to obtain your child's electronic Medication History?

_____ yes _____no

Does your child have any allergies?

_____ yes _____no If yes, please list below.

_____

Please list any medications your child is currently taking:

_____

What pharmacy do you regularly use?

Parent Name:_____

Parent Signature: _____ Date:_____

New Patient History Form

100 DEAN DRIVE, MOUNT ORAB, OHIO 45154
PHONE: 937-444-0035 FAX: 937-444-0036

CHILD'S LEGAL NAME: _____ **BIRTHDATE:** _____

BIRTH HISTORY:

AT WHAT HOSPITAL WAS THE CHILD BORN: _____ CITY: _____
BIRTH LENGTH: _____ BIRTH WEIGHT: _____ WAS THE CHILD BORN: VAGINAL OR C-SECTION
ANY COMPLICATIONS DURING PREGNANCY/DELIVERY? YES NO
IF THERE WERE COMPLICATIONS, PLEASE EXPLAIN: _____
WAS THE CHILD BORN WITHIN 3 WEEKS OF DUE DATE? YES NO
FOR NEWBORNS ONLY: WAS THE NEWBORN HEARING SCREEN NORMAL: YES NO
WHAT DATE WAS HEPATITIS B INJECTION GIVEN: _____
WAS THE BABY'S FOOT STUCK FOR METABOLIC SCREEN: YES NO

PREVIOUS SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS ILLNESSES:

DESCRIPTION	WHEN	WHERE

SOCIAL HISTORY:

ARE ANY MEMBERS OF THE CHILD'S HOUSEHOLD EXPOSED TO ANY CHEMICALS AT WORK? _____
DOES THE CHILD LIVE NEAR ANY FACTORIES OR PLANTS? YES NO
DOES THE PATIENT CURRENTLY LIVE IN A/AN (PLEASE CIRCLE ONE OF THE FOLLOWING):
SINGLE FAMILY HOME APARTMENT CONDOMINIUM MOBILE HOME PUBLIC HOUSING
IS THE CHILD EXPOSED TO LEAD BASED PAINT? YES NO
IS THE CHILD EXPOSED TO SECONDHAND SMOKE? YES NO
IS YOUR HOUSE SUPPLIED BY WELL WATER? YES NO
WAS THE CHILD'S HOME BUILT PRIOR TO 1978? YES NO
WHO DOES THE CHILD CURRENTLY LIVE WITH? _____
WHO DOES THE CHILD RELY ON FOR SOCIAL SUPPORT? _____
ARE THERE PETS IN THE HOME? YES NO IF SO, WHAT TYPE OF PET/S? _____

FAMILY MEDICAL HISTORY:

PLEASE NOTE IF ANY OF THE CHILD'S FAMILY MEMBERS (PARENTS, SISTERS, BROTHERS, AUNTS, UNCLES, GRANDPARENTS) HAVE ANY OF THE FOLLOWING.

ALCOHOLISM _____
ALLERGIES _____
ANEMIA _____
ASTHMA _____
BLEEDING DISORDER_____
COMPLETED STROKE_____
DIABETES _____
DISORDER OF LUNG_____
DRUG ABUSE_____
EPILEPSY (SEIZURES) _____
CANCER (TYPE)_____
LOW VISION _____
GENETIC DISORDER CARRIER _____
HEARING LOSS _____
HEART DISEASE_____
HEPATITIS_____
HIV _____
HYPERTENSIVE DISORDER_____
MENTAL DISORDER_____
MIGRAINE_____ _____
TUBERCULOSIS_____

PLEASE SEE OTHER SIDE OF FORM-→

SOCIAL DETERMINANTS OF HEALTH

ARE YOU AT RISK OF BECOMING HOMELESS? YES NO

IF YES, WOULD YOU LIKE HELP WITH THIS? YES NO

ARE YOU FEELING SAD OR HOPELESS A LOT OF THE TIME? YES NO

IF YES, WOULD YOU LIKE HELP? YES NO

DO YOU NEED DAYCARE? YES NO

IF YES, WOULD YOU LIKE HELP FINDING IT? YES NO

DO YOU NEED HELP IN GETTING FOOD BY THE END OF THE MONTH? YES NO

IF YES, WOULD YOU LIKE HELP WITH THIS? YES NO

DOES ANYONE IN THE HOUSEHOLD HAVE A PROBLEM WITH ALCOHOL? YES NO

IF YES, WOULD THEY LIKE HELP? YES NO

DOES ANYONE IN THE HOUSEHOLD NOT HAVE A HIGH SCHOOL DEGREE? YES NO

IF YES, DO THEY NEED HELP GETTING A GED? YES NO

DOES ANYONE IN THE HOUSEHOLD NOT HAVE A JOB? YES NO

IF YES, WOULD THEY LIKE HELP FINDING EMPLOYMENT? YES NO

DOES ANYONE IN THE HOUSEHOLD SMOKE CIGARETTES? YES NO

IF YES, WOULD THEY LIKE HELP TO QUIT? YES NO

HAS ANYONE HIT OR VERBALLY ABUSED YOU? YES NO

IF YES, WOULD YOU LIKE HELP? YES NO

DOES ANYONE IN THE HOUSEHOLD USE DRUGS? YES NO

IF YES, WOULD THEY LIKE HELP? YES NO

If you selected YES for help with any of the above questions, please reference out website for resources
https://www.allaboutkidspeds.com/online-resources.html
Or visit findhelp.org by findhelp - Search and Connect to Social Care for local resources

FOR FEMALES, AGES 12 AND ABOVE

AGE WHEN PERIOD STARTED _____ DATE OF LAST PAP SMEAR _____ DATE OF LAST PERIOD _____

ANY CRAMPING WITH PERIODS (PLEASE CIRCLE ONE): NONE MILD SEVERE

PERIODS ARE CONSIDERED (PLEASE CIRCLE ONE): REGULAR IRREGULAR ABSENT

HISTORY OF ABNORMAL PAP SMEAR? YES NO

MENSTRUAL FLOW IS (PLEASE CIRCLE ONE): NORMAL LIGHT HEAVY ABSENT

DOES CHILD USE CONTRACEPTION? YES NO

IF USING CONTRACEPTION, WHAT FORM? _____

HISTORY OF BREAST LUMP? YES NO

IS CHILD SEXUALLY ACTIVE? UNKNOWN YES NO

NUMBER OF MISCARRIAGES _____ PREGNANCIES?_____ABORTIONS? _____ STILLBORNS?_____TWINS? _____

BREAST CANCER HISTORY IN ANY OF THE FOLLOWING (PLEASE CIRCLE ANY THAT APPLY):

SELF MOTHER SISTER GRANDMOTHER AUNT

all about KIDS pediatrics

Late Arrival Policy

Our providers, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is late/ arrives at any time after their scheduled appointment time for any appointment other than a sick visit, the appointment will need to be rescheduled.

If a patient is more than 10 minutes late for a sick appointment, the appointment may need to be rescheduled. This is at the provider's discretion, based on scheduling demands for the day. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

Making and Keeping Appointments

When you make your appointment, be sure to let our receptionist know the nature of your visit (ear pain, rash, complete physical). Also, please let us know at the time you make your appointment if you have a lot of questions/concerns so we can schedule enough time for your visit. If we try to squeeze multiple issues into a single "quick visit", it either results in cutting you off (not fair to you) or making our other patients wait while we finish (not fair to them).

1. The first no show that occurs will result in a phone call reminding you that you missed your appointment and to reschedule.
2. The second no show will result in a letter reminding you that you missed your appointment and to reschedule.
3. The third no show will result in a warning letter of dismissal
4. The fourth no show will result in termination of physician-patient relationship. This will be determined by the doctor.

Prescription Refill Request

When calling in for a prescription refill, please allow 72 business hours for the request to be completed. Please plan ahead so you do not run out of important medications.

Patient Name: _____ Date of Birth:_____

Parent/Guardian Signature: _____ Date: _____

Revised 11/7/2022