

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Allergies: _____

Current Medications: _____

Birth History:

Birth Weight: _____ Birth Hospital: _____

Boy or Girl

Full Term (>37 weeks) or Premature (<37 weeks)

Vaginal - Use of Forceps or Vacuum

C/Section - Due to: _____

Pregnancy Concerns: _____

Newborn Concerns: _____

Child's Past Medical History:

Does your child have a history of any medical conditions? Yes or No

If **YES** please circle below any that apply:

Genetic:	Chromosome Abnormality			
Development:	Delay-Speech/Language	Delay-Motor Skills	Autism	
Learning:	Special Education	Dyslexia		
Behavior/Mood:	Obsessive-Compulsive	Depression	Anxiety	ADHD
Hearing:	Ear Tubes	Hearing Loss		
Vision:	Strabismus	Amblyopia	Cataract	Glasses
Neurologic:	Head Trauma	Concussion	Seizures	Migraine
Respiratory:	Seasonal Allergies	Asthma	Pneumonia	RSV
Cardiac:	Heart Murmur	VSD/ASD	Arrhythmia	
Endocrine:	Thyroid Disease	Diabetes		
Gastrointestinal:	Acid Reflux	Jaundice	Bowel Disease	
Urology:	Bladder Infections	Kidney Disease	Kidney Stones	
Genital:	Vaginal Discharge	Menstrual Problems	STD	
Muscle/Bone:	Broken Bone(s)	Scoliosis	In Toeing	Club Foot
	Club Foot	Hypotonia	Spinal Bifida	
Skin:	Hemangioma	Eczema	Acne	Vitiligo
	MRSA	Warts		
Infections:	Meningitis	HIV	TB	Scarlet Fever
Cancer:	Leukemia	Cancer/Tumor		
Blood:	Anemia	Sickle Cell	Hemophilia	

Other Medical Conditions: _____

Has your child ever seen a specialist (medical or mental health) Yes or No

If **YES** please describe who and why: _____

Child's Past Surgeries:

Tonsils/Adenoids Ear Tubes Hernia Repair Circumcision Appendectomy

Other Surgery Related to:

Heart Mouth/Face Bones/Muscles Kidney/Bladder Genitals Eyes
Genitals Eyes Intestines/Colon

Hospitalizations: _____

For females- Age of first period: _____

Family History:

List any medical conditions with the child's family members:

(mom, dad, siblings, child's grandparents, child's aunts, uncles, cousins)

Disease/Condition	Who	Age	Comments
Heart Attack			
Other Heart Problems			
Diabetes			
Seizures			
High Blood Pressure			
High Cholesterol			
Cancer			
Blood Disorder			
Congenital Disorder			
Allergies/Asthma			
Mental Health			
Other			

Care/Education:

Home Daycare Preschool K-12th grade Home school College

Activities:

Participate in any sports? Yes or No

If **YES** what type? _____**Home Environment:**

Parents: Married Live Together Divorced Single Parent

Patient lives with: Both Parents One Parent: _____ Other: _____

Parent Occupation: _____ Parent Occupation: _____

Siblings:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Smokers: Yes or No

Pets: Yes or No type: _____

How did you hear about our practice? _____

Milestone Pediatrics

Office Policies

Red Flag/Identity Theft

Our office strives to prevent the intentional misuse of patients' names, identities, and medical records to report criminal activity relating to identity theft to appropriate authorities. As a result, a copy of your photo ID and insurance card will be collected during the patient registration process. A copy of our office's Identity Theft Policy is available for your review.

Additional Fees

In the event that any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur. A \$35.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees required.

Form Completion

We follow Illinois law regarding medical record copying fees. If your child has school, camp, or sports forms to be completed, we have a 3 to 5 day turnaround time for forms. **There is a \$15.00 fee for FMLA or disability form completion.**

Missed Appointments

We request **24 hour notice** for canceling any appointments. If 3 or more appointments are missed or canceled on the same day, you may be dismissed from the practice. **You may incur a \$50 charge for each missed or same day canceled appointment.**

Late Policy

Our office policy is to see our patients at their scheduled time. Sometimes, unforeseen situations occur that make our providers run behind schedule. We will always try to keep you informed if we are running late. In order to stay on time, we need our patients to be on time. If you are running late, please call our office and make us aware, we may ask that you reschedule your appointment in order to serve all of our patients.

Notice of Private Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operation. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our Practice Manager.. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Patient Name _____ Date of Birth: _____

Signature of Parent/Guarantor _____ Date: _____

Print Name of Parent/Guarantor _____

4/9/25

Authorizations and Agreements

Authorization for Treatment

I agree to any examination, treatment, and procedure that may be performed during office visits, including emergency treatment, considered necessary by the physician and/or his/her healthcare providers.

Vaccine Policy

We STRICTLY follow the American Board of Pediatrics Guidelines for vaccinations. We do NOT accept any alternate or non-vaccinators. **By signing below you are agreeing to our policy.**

Release of Information

I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological) advice, treatment, or supplies provided to me for the purpose of administration, review, investigation, or evaluation. A photo static of this authorization shall be considered as effective and valid as the original. I will notify the facility in writing of any information I do not want released.

Assignment of Insurance Benefits

I authorize the assignment of benefits payable to Milestone Pediatrics and/or its designee for physician services and supplies by government and or any other private third party payer. **I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.**

Financial policy

Co-Payments are required to be paid at the time of checking in for your appointment. If you are unable to pay at that time, a **\$25.00** surcharge will be applied to the account if the co-pay is not paid within 3 business days.

Self-Pay Accounts are required to be paid at the time of check-in

Insurance- as a courtesy, our office will bill all insurance companies for the services provided. Upon response from your insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid in full within 30 days of receiving the billing statement. It is your responsibility to notify our office of any insurance or demographic changes. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payments at the time of visit.

Divorced/Separated & Co-Parenting Parents-The parent/guardian that presents the child for medical services is the financially responsible party. If there is a financial arrangement between individual parental parties, this arrangement is between the two parties and does not absolve the parent that brings the child in for services from their financial obligation to our office. Our office will not be involved with separation or divorce disputes.

I agree to pay any outstanding balance within 30 days after receiving a statement from Milestone Pediatrics notifying me of such balance.

If previous arrangements have not been made with our billing department, any account balance outstanding greater than 30 days will be charged a **\$10.00 re-bill fee**. Any balance over 60 days will be forwarded to a collection agency, additional charges may apply and your family may be dismissed from the practice.

Not all plans cover annual healthy (well) physicals, hearing/vision screenings, developmental questionnaires, and postpartum screens for mom, earwax removal, rapid strep, flu, RSV, mono and stool occult blood testing, vaccinations. If any of these services are not covered, you will be responsible for payment.

Referrals/Preauthorizations

It is your responsibility to understand your benefit plan and know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered.

Advance notice is needed for all non-emergent referrals, most insurances require 7 to 10 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, your primary care physician must approve referrals before being issued.

Release of Medical Records

Consent for release of medical records is required to be signed by a parent/legal guardian of the minor or adult patient prior to release of records completion. This includes school, camp, sports, FMLA, disability, etc. We follow Illinois law regarding record copying fees.

Consent for Access to Health Information by Providers

By signing this form, I give my permission practice to send and receive my health information for the following treatment purposes:

Data Sharing for Treatment Purposes: Practice has the ability to share you/your child's health information with your other providers through electronic data sharing programs:e.g., Epic Care Everywhere®, Carewquality, and EpicCare® Link) or other similar data sharing programs. I give permission to practice to share my health information with my other providers at other locations. This may include my Highly Confidential Health Information¹, for the purposes of care, treatment and care coordination. If I prefer not to share my data in this way, I do not have to sign this form but this will mean my data cannot be shared by these data sharing programs automatically, *including in an emergency situation*.

Illinois Immunization Registry: Practice may disclose information concerning your immunization records to the Illinois Department of Public Health ("IDPH") for inclusion in a centralized database for children's immunization records. Such information may be used by IDPH, public vaccine providers, community health centers, the Centers for Disease Control and Prevention, or any other person or entity providing immunization services or approved by IDPH as needing to know your health or immunization status. Such information may be used by these recipients to: provide immunization services to you; monitor your immunization status; promote adherence to recommended immunization schedules; assist in the preparation of vaccination documentation required by your school; prepare statistical reports on immunization status of groups of patients in which neither you nor any other patient may be individually identified; and otherwise monitor and promote your health and the health of children in Illinois generally. If I prefer not to share my data in this way, I do not have to sign this form but this will mean that my data cannot be shared by these data sharing programs automatically, *including in an emergency situation*.

Revocation: You may revoke your authorization to disclosure information by notifying practice of such revocation in writing. Revocation will not affect any disclosures already made *prior* to notice of revocation to practice.

Expiration: Your authorization is valid for one (1) year.

SIGNATURES:

Patient ages 12-17 years must also sign

Patient Name/Signature:

Parent/Legal Guardian Signature and Relationship to Patient:

Consent for Treatment

Treatment: I the patient/parent/legal guardian, with my signature, authorize this practice and by employee/staff working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian, or for which I am the legal ability to provide consent. This medical care may include, but shall not be limited to, preventative, diagnostic, therapeutic, rehabilitative, counseling, assessment or review of physical or mental status/function of the body, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent encompasses contact and discussion with other health care professionals for health care and treatment, and use of my demographic information for health care operational and billing purposes.

Payment: In consideration of any medical care provided to the patient, I assign to practice and providers associated with practice all my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by the practice.

I agree that all telephone numbers and email addresses I provide as contact information to practice may be used by the practice and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages, for all treatment, payment and operational purposes.

Expiration: Your authorization is valid for one (1) year.

SIGNATURES:

Patient ages 12-17 years must also sign

Patient

Name Printed:

Signature:

Parent/Legal Guardian Signature:

Relationship to Patient:

NOTICE OF PRIVACY PRACTICES

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.

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practice. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called “protected health information” or “PHI”. We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone

who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: If the practice participates in research, we may use or disclose your patient information without your authorization if an Institutional Review Board approves a waiver of authorization. If a waiver has not been approved, we will obtain your written authorization as required by law before your health information is used for research.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Autodial and Electronic Contact: I authorize you, your affiliates, business associates and agents to contact me at the telephone numbers I have provided you. Contact may be by using autodialed calls, text messages, and artificial voices or prerecorded voices, for purposes of your healthcare operations, billing, collections and other account activities, patient surveys, and marketing. I understand that I am not required to provide this call authorization and it is not a condition to receiving healthcare services. I may revoke this call authorization at any time by notice to you.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure

of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with our office. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations). You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

Your health information is kept in an electronic format. A Health Information Exchange allows health care providers to access clinical information about patients from other treating facilities. The practice participates in two health information exchanges: the Community Connect Health Information Exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago (the "Exchange"), and CareEverywhere®.

- Community Connect Health Information Exchange. We, along with certain other health care providers and practice groups in the area, participate in a health information exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's"). The Exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information
- regarding patients among health care providers that participate in the Exchange, including Lurie Children's Affiliates. Through the Exchange, we may electronically disclose demographic information including cellular phone numbers and/or email addresses you provide, and medical, billing, and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations.

- CareEverywhere®. We have a software product called CareEverywhere® that allows us to exchange health information with other providers that have the CareEverywhere® product. The CareEverywhere® exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers also have the CareEverywhere® software. Through the software CareEverywhere®, we may electronically disclose demographic, medical, billing, and other health-related information about you to other health care providers that participate in the Exchange and request such information for the purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations. Due to our participation in the Exchange, your electronic health information from our practice may be made available to other providers through Lurie Children's shared electronic medical record.

You may opt out of participation in the exchanges described above at any time by contacting the practice. Health information that has already been shared cannot be revoked. However, if you do not consent to sharing health information for treatment purposes in the health exchanges described above, your health information will not be stored in an electronic health record. Hardcopy (paper) health records may not be immediately available or transmittable to your other health care providers for treatment purposes, including in emergency situations.

Illinois Immunization Registry: We may disclose information concerning your immunization records to the Illinois Department of Public Health ("IDPH") for inclusion in a centralized database of children's immunization records. Such information may be used by IDPH, public vaccine providers, community health centers, the Centers for Disease Control and Prevention, or any other person or entity providing immunization services or approved by IDPH as needing to know your health or immunization status. Such information may be used by these recipients to: provide immunization services to you; monitor your immunization status; promote adherence to recommended immunization schedules; assist in the preparation of vaccination documentation required by your school; prepare statistical reports on immunization status of groups of patients in which neither you nor any other patient may be individually identified; and otherwise monitor and promote your health and the health of children in Illinois generally. You have the right to opt out of participating in this registry.

You may opt out of certain provisions of the Notice, as indicated herein, by providing separate written notice. We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice at our office or on our practice website. Changes to the Notice are applicable to the health information we already have.

Parent/Guardian Signature for patient under 18 years of age:

Insurance Authorization

By signing this form, I acknowledge that I have or will provide my current insurance card to the practice.

I have contacted or will contact my insurance company to verify that this practice is under contract and in network with my insurance company.

I acknowledge that it is my responsibility to understand my insurance benefits.

I understand that the practice will submit claims to my insurance company as a courtesy, and that if there are questions or concerns, it will be my responsibility to call my insurance company.

I understand that all copays are due at the time of service and that all balances not paid by insurance are my responsibility.

Parent or Legal Guardian Signature:

Telehealth Patient Consent Form

Telehealth, or a “virtual visit”, is a consultation with one of our physicians via video conferencing. This is something we are offering at a time when we are trying to minimize face-to-face interactions in the interest of keeping your family and community healthy.

Virtual visits are convenient, allow your child to be seen without coming into our office, and provide care by your regular pediatrician (who knows your child’s full history, and has access to their medical chart.) However, as we cannot listen to your child’s lungs or see their ears, we may not be able to fully evaluate ear pain and significant coughs in a virtual visit, and we may not be able assess concerns that require laboratory evaluation, such as urinary tract infections and strep or flu testing, with a virtual visit alone. It is possible that after video-conferencing, the doctor may ask you to bring your child in for an in-person sick visit if we need to perform a physical exam or specific test that reaches beyond the abilities of video conferencing.

Virtual visits are not for all conditions. Our doctors and triage nurses will work together to determine which type of visit is most appropriate for the safety and health of your child.

Scheduling:

Appointments for telehealth visits can be made with our triage nurses - the specific times will be determined based on need and the availability of the physicians.

Payment:

Telemedicine parity laws require private payers to pay for telemedicine services the same way they would in-person services. Unfortunately, Illinois does not have a private payer parity law yet, so coverage by private payers isn't mandated. However, in light of Coronavirus, many insurers are now offering payment. For now our virtual visits will be charged a fee comparable to that of an office visit, based on complexity of the issue addressed.

We will bill your insurance company, as we do with other visits, and like those, you will be responsible for the balance. If you do not submit charges to insurance, we are able to provide a prompt pay discount, if paid within 24 hours.

How to join a call that has been scheduled for you

We are providing video conferencing through a video conferencing platform that is HIPAA secure. All data is encrypted, your sessions are anonymous, and none of your information is stored.

No need to download software or create an account. Just use a browser (preferably Chrome) on a computer, smart phone or device with a camera and microphone.

To connect with your doctor, the triage nurse will email you a link and you can sign on as directed 10-15 minutes before the call to join the doctor for a video call. The office will assign you the physician link. I agree to receive this health care service.

A Telehealth service means that a doctor at our practice has determined that a telehealth visit is appropriate and will happen by using HIPAA compliant video conferencing. This consent is valid for one year for follow-up telehealth services with the health care providers at our office.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the Telehealth Service.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I agree to an "in-person" visit if the doctor decides is necessary.
- Telemedicine parity laws require private payers to pay for telemedicine services the same way they would in-person services. Unfortunately, Illinois does not have a private payer parity law yet, so coverage by private payers isn't mandated. However, in light of Coronavirus, many insurers are now offering payment. For now, our virtual visits will be charged a fee comparable to that of an office visit, based on complexity of the issue addressed. We will bill your insurance company, as we do with other visits, and like those, you will be responsible for the balance.
- Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payer.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for my child for 1 year from date signed.

Patient Name:

Parent/Legal Guardian Signature:

Date:

PATIENT(S) INFORMATION

Name: _____ Male/Female/preferred pronoun _____ D.O.B. ____/____/____ Ethnicity: _____
Name: _____ Male/Female/preferred pronoun _____ D.O.B. ____/____/____ Ethnicity: _____
Name: _____ Male/Female/preferred pronoun _____ D.O.B. ____/____/____ Ethnicity: _____
Name: _____ Male/Female/preferred pronoun _____ D.O.B. ____/____/____ Ethnicity: _____
Name: _____ Male/Female/preferred pronoun _____ D.O.B. ____/____/____ Ethnicity: _____
Family Status: Married _____ Divorced _____ Widowed _____ Single _____
Child(ren) live with: _____

PARENT/GUARDIAN INFORMATION

Mother	Father	Guardian	Mother	Father	Guardian
Name: _____			Name: _____		
Address: _____			Address: _____		
City: _____ State: _____ Zip _____			City: _____ State: _____ Zip _____		
Cell: _____			Cell: _____		
Employer: _____			Employer: _____		
Occupation: _____			Occupation: _____		
Birthdate: _____			Birthdate: _____		
Social Security #: _____			Social Security #: _____		
E-mail: _____			E-mail: _____		

COMMUNICATION/EMERGENCY CONTACT

If we are unable to reach you, is it okay to leave confidential information on your voicemail? **YES NO**

If yes, please list phone number: _____

In case of an emergency who should we contact? (other than parent/legal guardian)

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

Authorized persons

Name(s) of Person authorized to accompany child(ren) for medical treatment and to make medical decisions and disclose medical information regarding my child(ren) in the event that a parent /legal guardian is unavailable.

I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request. ***A parent or legal guardian MUST be present at visits where vaccines will be given.**

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Print Name: _____ Signature: _____ Date _____