The Children's Clinic of Klamath
Updated Heath History Questionnaire

Patients Name: _____ Date of Birth: _____

Family History: Has your child or a family member had any of the following? Date: _____

	Patient:	Family Member:	Relationship:
Allergies:	_____	_____	_____
Anemia:	_____	_____	_____
Asthma:	_____	_____	_____
Birth defects:	_____	_____	_____
Bleeding disorder:	_____	_____	_____
Breast problems:	_____	_____	_____
Cancer:	_____	_____	_____
Depression	_____	_____	_____
Diabetes:	_____	_____	_____
Ear infections:	_____	_____	_____
Eczema:	_____	_____	_____
Headache/migraines	_____	_____	_____
Heart issues:	_____	_____	_____
High blood pressure:	_____	_____	_____
Seizures:	_____	_____	_____
Substance abuse:	_____	_____	_____
Obesity:	_____	_____	_____

Has your child seen a dentist: _____ eye doctor: _____ in the past year?

Has your child been to the ER: _____ or Urgent Care: _____ in the past year?

Are there smoke alarms in the home: Yes _____ No _____ Carbon monoxide detector: Yes _____ No _____

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Updated Health History Questionnaire

For children under age 3

Has your child met expected milestones? (e.g., sitting, crawling, walking, talking): Yes _____ No _____

If no, please explain: _____

Any concerns about behavior, sleep, or feeding? Yes _____ No _____

Does your child respond to sounds, voices, or facial expressions? Yes _____ No _____

Do you have any vision and hearing concerns? Yes _____ No _____

Allergies to medications or foods? Yes _____ No _____

Is your child up to date on vaccines? Yes _____ No _____

If you answered no please explain why _____

Does your child have a dental home? Yes _____ No _____

Does your child attend daycare? Yes _____ No _____

For children 3 years and older

Does your child attend daycare, pre-school or Head Start? Yes _____ No _____

What school does your child attend? _____

What grade is your child in? _____ Have they ever repeated a grade? Yes _____ No _____

Do they attend any special classes? Yes _____ No _____

Do they have a 504 or IEP? Yes _____ No _____

Any behavioral concerns at school? Yes _____ No _____

Any academic concerns at school? Yes _____ No _____

If you answered "yes" to any of these questions please describe:

_____

_____

_____

_____

"Growing Up Together"
2580 Daggett Ave
Klamath Falls, OR 97601
Ph: 541-884-1224
Fax: 541-884-8030
cckonline.com

The Children's Clinic of Klamath
Clinic Policies

Thank you for choosing The Children's Clinic of Klamath for your child's medical care. Please review the following policies and procedures below and sign where indicated.

Patient Name: _____ Date of Birth: _____

- Patient's must arrive 15 minutes before their scheduled appointment time. Please provide their insurance card and insurance copay if applicable at check in. We have a contractual obligation to your insurance company to collect copays at the time of service.
- Any outstanding balances due to deductibles, co payments and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full please contact our billing office at 541-882-1540 to make payment arrangements. Non-payment of charges will result your account being turned over to a collection agency and your family may be discharged from the practice.
- A no show or late cancellation fee of $50 may be charged to patients who do not provide a 24 hour notice to cancel an appointment or for patients who have "no call no showed" their appointment. After 3 no shows or late cancellations you may be discharged from the practice.
- If you arrive more than 15 minutes late for your appointment you may be asked to reschedule depending on the offices availability for the day.
- If your child is being seen for a well child check up and you have other concerns that are not related to routine wellness care, those concerns may generate additional charges to your insurance and you may be asked to schedule another appointment to discuss these concerns.
- Our office is open Monday through Friday 8:00am to 5:00pm. After hours we offer a telephone triage consultation that puts you in touch with a pediatric trained nurse. You may reach this service by calling our office and following the prompts. We offer this service to help save on costs and high wait times for possibly unnecessary trips to Urgent Care or the Emergency Room. You may also find the answers to your questions on our website at cckonline.com.
- Please allow 3 business days for all requested forms and prescription refill requests.
- The Children's Clinic of Klamath will only use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all of the patients health information to not be disclosed in the manner described in the Notices of Privacy Practices. The Children's Clinic of Klamath is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance with HIPAA.
- We keep a record of health care services that we provide to your child. You may ask to see that record (copy charges may apply). You may ask us to correct that record, although we may not agree. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Please contact us to see the records or get more information.

I, _____ the parent or legal guardian of _____
Authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked.

I acknowledge with my signature that I have read and understand the above information.

Parent/Guardian Signature: _____ Date: _____

The Children's Clinic of Klamath Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

INSURANCE:

Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide **ACCURATE** and **TIMELY** insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor/patient being responsible for payment. All patient balance questions should be made directly to your insurance for an explanation of benefits.

NON-EMERGENCY APPOINTMENTS:

Well visits, physicals, any non-emergent follow ups and visits may be rescheduled if there are outstanding balances or co-pay is not paid at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (including vaccine and doctor visit coverage, referral/authorization requirements for specialty care, x-rays, lab tests, emergency hospital care, ect.).

BILLING:

We accept cash, checks, American Express, Discover, MC or Visa. Co-pays are due at the time of service. Deductibles and any patient responsible balances will be billed to the patient. Outstanding balances are due within 30 days of the statement date, unless prior arrangements have been made with the office. Balances not paid within the 30 days of the first statement date may be subjected to cancellation of your next appointment. Balances not paid in full witbin 90 days of the initial statement date will be forwarded to a collection agency. If your account is sent to collections a second time, your family will be dismissed from our practice.

A $35.00 fee will be charged for all returned checks and your account will be placed on a "cash or credit card basis only." We will accept payments by cash or credit card only until the balance is cleared.

For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital/custodial disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing office promptly at 541-882-1540 for payment arrangements and assistance in the management of your account.

Should your account balance become un-collectible due to bankruptcy, you could possibly be discharged from the practice.

IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:

All services performed in our office and at the hospital will be submitted as a courtesy to your insurance. All co-pays are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. Not all services provided by this office are a covered benefit with all insurance plans. You may be asked to sign a waiver that you understand this and may be responsible for the costs.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:

We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. ***Be prepared that you will not always be reimbursed the full price amount you paid for your services by our physician. We will not reimburse you the difference between the reimbursement rate your insurance pays you and our fee for our services. Payment for services is due at the time of service.

MISSED APPOINTMENT/LATE CANCELLATIONS:

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a $50.00 fee for any missed appointments. We request that you cancel any appointments at least 24 hours in advance of your appointment time. We understand that emergencies happen, please reach out to us as soon as possible regarding your missed appointment. After three missed appointments without notification, our office may discharge you from the practice.

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE CHILDREN'S CLINIC OF KLAMATH. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, MY FAMILY MAY BE DISCHARGED FROM THE PRACTICE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT/GUARANTOR.

Signature of Patient/ Responsible person:_____

Print name:_____

Date: _____

The Children's Clinic
of Klamath

14 years and Older Release of Information

Patient Name: _____

Date of Birth: _____ Age: _____

Patients Phone Number: _____

It is okay for The Children's Clinic of Klamath to leave a detailed message on my voicemail, including test results. **Initials:** _____

I give my permission for The Children's Clinic of Klamath to contact my parents/guardians regarding test results. **Initials:** _____

I give my parents/guardians permission to access my medical records through the patient portal or request them on my behalf. **Initials:** _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

I **DO NOT** give my parents/guardians to access and/or view my medical records or receive test results. **Initials:** _____

Printed name of patient: _____

Signature of patient: _____

Date: _____