Beyond Care Pediatrics

Patient Information & Contact Authorization (0-18 years)

Patient's Name _____ DOB _____ Male / Female _____

Address: _____

City _____ State _____ Zip: _____

Mother's Name _____ Phone# _____ DOB _____

Father's Name _____ Phone # _____ DOB _____

Patient Portal and Patient Reminders

Email: _____

Cell Phone Number for Text Appointment Reminder _____

◯ OK to send texts for appointment reminders or voicemails with lab results or med changes.

◯ DO NOT LEAVE MESSAGES OFANY KIND

Insurance Holder/Responsible Party

Name _____ Relationship to Patient _____ DOB _____

SS#: _____ Ins.Name _____

Employer _____

Please list Anyone (other than Mother and Father) authorized to talk with Doctor/Nurse/Staff regarding your child's healthcare:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Beyond Care Pediatrics POLICIES

We recognize that sometimes conflicts arise that prevent patients from attending scheduled appointments. However, when patients fail to cancel scheduled appointments when conflicts arise, we miss an opportunity to schedule other patients in the appointment slot who may really need medical attention.

To provide quality care for as many patients as we can, in any given day, we try to strictly adhere to our late, cancellation and no-show policy.

Cancellation Policy

There is no penalty for cancelling scheduled appointments ahead of time. We get it... stuff happens! We will work with you to reschedule your child's appointment for a date and time that work better for you and your family.

Please call to cancel appointments at least 24 hours in advance.

If you call to cancel your appointment less than 30 minutes prior or call after your scheduled appointment, this will be considered a no-show. Initial here_____

No Show Policy
A no-show is considered not showing up for a scheduled appointment or phoning in to cancel/reschedule the appointment less than 30 minutes prior to the scheduled appointment.

If children were scheduled together (siblings) and the appointment is no-showed, we are unable to reschedule the siblings together for a second time.

You will be notified via letter to your home address if you have no-showed an appointment.

If you continue to no-show, we may have no other option than to dismiss you from our clinic. Initial here:_____

Late Policy

If you arrive to your scheduled appointment later than 15 minutes, we may have to reschedule your appointment. Initial here:_____

I have verified all the above information, understand the no show/late policies, and have given my consent to contact me as noted in this document

Signature: _____ Date: _____

Beyond Care Pediatrics • 16945 Frances St • Omaha, Ne, 68130 • tele# 402.991.5690 • Fax # 531.600.6282

Beyond Care Pediatrics
16945 Frances St Ste 200 B
Omaha, NE 68130
Phone: (402)991-5690
Medical Records Fax: (800)557-1226
Bernard Douglas, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

Home Phone#: _____ Cell/Home

Other Phone#:_____ Cell/Home

I authorize the release of my medical records from the Physician/Medical office(s) list below:

_____

_____

_____

_____

I also give consent to the staff Beyond Care Pediatrics/Bernard W. Douglas, MD to view and/or print my personal health information from the CHI Health EPIC System and Methodist Health Cerner System and CyncHealth Systems..

NO CD'S ACCEPTED- PAPER COPIES ONLY PLEASE

I understand the above named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2

Patient/Guardian Signature_____ Date: _____

**This Authorization is Valid for 365 days from date of signing.

Beyond Care Pediatrics
16945 Frances St Ste 200 B
Omaha, NE 68130
P: (402)991-5690
Fax: (531)600-6282
Bernard Douglas, MD

Patient Name: _____ Date of Birth: _____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from
my pharmacy, my health plans, and my other healthcare providers.

_____ _____
Signature or Patient or Legal Guardian Date

_____
Patient or Guardian name printed legibly:

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression