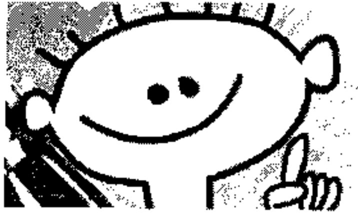

Kids First Pediatrics, Ltd.
24600 West 127th Street
Building B, Suite 345
Plainfield, IL 60585
(815) 609-KIDS (5437)
(815) 609-8111(Fax)

Please Fill Out Completely

PATIENT INFORMATION

Last Name: ______________________ **Alternate Last Name:** ______________________

First Name: ______________________ **Nickname (if any):** ______________________

Middle Initial: _____ **Date of Birth:** ____/____/____

Sex: ☐ Male ☐ Female **Social Security No:** ______________________

Home Address: ______________________ **Home Phone Number:** ______________________

______________________ **Cell Phone Number:** ______________________

Names of Siblings in Practice: ______________________

PARENT/GUARDIAN 1 (Person who holds insurance – Please enter name *exactly* as it appears on insurance card)

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian ☐ Step-Parent ☐ Other: __________

Last Name: ______________________ **Alt. Address (if different than patient)**

First Name: ______________________ ______________________

Lives with Patient: ☐ Yes ☐ No ______________________

Social Security Number: ______________________ **Date of Birth:** ____/____/____

Cell Phone Number: ______________________ **E-mail Address:** ______________________

Work Phone Number: ______________________

PARENT/GUARDIAN 2

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian ☐ Step-Parent ☐ Other: __________

Last Name: ______________________ **Alt. Address (if different than patient)**

First Name: ______________________ ______________________

Lives with Patient: ☐ Yes ☐ No ______________________

Social Security Number: ______________________ **Date of Birth:** ____/____/____

Cell Phone Number: ______________________ **E-mail Address:** ______________________

Work Phone Number: ______________________

INSURANCE INFORMATION

Primary Insurance Carrier: ______________________ **Address to "send claims to:"** *(Often on the back of the card)*

Subscriber ID: ______________________ ______________________

Group ID #: ______________________ ______________________

Co-Pay Amount: $______________ ☐ Check if there is a secondary insurance.

How did you hear of us? ☐ Friend/Neighbor ☐ Web Site ☐ Former Patient ☐ Other: __________

Thank you for choosing us for your health care needs. We are dedicated to providing high quality medical care and look forward to building a long-term relationship with you and your family. Below is our financial policy. Please read and sign in the appropriate section.

Payment

Payment in full for your estimated co-payment is due at the time of your visit, unless other arrangements have been made with the Billing Department. **We require a credit card to be saved on file for all medical costs that are not covered by your insurance policy.** If a balance on the account is not paid within **60 (sixty) days** after your claim has been processed by your insurance policy, your credit card HSA or credit card on account will be billed for any amount due (noted as "patient responsibility"). For bills over $100, the billing department will call the number on file prior to submitting the payment. With arrangements with the billing department, we also accept the following forms of payment:

- Cash, Check, Debit, Visa, MasterCard, Discover, and American Express
- We offer monthly payment plans as well

We do not send statements out under $10.00 (ten dollars). Someone from the billing department will contact you about these balances.

Insurance

Our office is committed to helping our patients maximize their benefits. Your insurance policy is a contract between you and your insurance company. As a service to our patients, if you bring in all your insurance information, we will bill your insurance company. If you cannot provide us with necessary insurance information, payments in full is expected and you will need to bill your insurance for reimbursement. No later price adjustments will be made after 90 days. You are responsible for any balance not paid over 90 days from date of service. It is your responsibility to provide our office with the current demographic and insurance information. Also, it is your responsibility to provide any information requested by your insurance company to have claims processed in a timely manner. **It is the policy holder's responsibility to know the details of their insurance policy and the extent of coverage regarding *all* office visits. We cannot guarantee coverage of services or procedures provided due to the complexities of the insurance contracts.**

Service Charge

We charge a $25.00 fee for returned checks.

Collection Fees

If any unpaid balance is delinquent, you are responsible for any late fees, collection fees, attorney, or court costs associated with recovery due on the patient account.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement.

Print name of patient ____________________ Print name of responsible party ____________________

Signature of patient/responsible party ____________________ Date ____________________

The Physicians, Nurse Practitioners and Staff at Kids First Pediatrics want to make sure that all our patients get the best care possible. It is important to us that any disparities in healthcare are addressed.

As part of the Lurie Children's Physician Partners network, we are able to provide our patients with access to numerous specialists in the Chicagoland area. Lurie Children's has tasked each of its physician practices with obtaining REaL data (Race, Ethnicity and Language) to ensure that every person of every background receives the highest quality of care. It is also important that we know your spoken language so that you and your child's health care team here at Kids First Pediatrics can have good communication.

We will keep this information private and will update it in your child's medical record. Your answers are confidential. You need not answer any question you prefer not to answer.

1. **Are you of Hispanic, Latino, or Spanish origin? (Mark ONE box.)**
   - ☐ YES_______________ (specify (e.g. Mexican, Puerto Rican, Cuban, etc))
   - ☐ No, not Hispanic, Latino, or Spanish origin

2. **What is your race? (Mark one or more boxes.)**
   - ☐ White/Caucasian
   - ☐ Black/African American
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Some other race: ____________________(specify)
   - ☐ Prefer not to answer

3. **IF MORE THAN ONE RACE (Question #2) IS CHECKED: Do you identify with any one race in particular?**
   - ☐ Yes __________________________(specify)
   - ☐ No

4. **What language do you feel most comfortable using with your healthcare providers and staff?**
   - ☐ English
   - ☐ Spanish
   - ☐ Another language: __________________________(specify)

Kids First Pediatrics, Ltd. | 24600 West 127th Street, Building B, Suite 345 | Plainfield, IL 60585
815-609-KIDS (5437) | Fax: 815-609-8111 | www.kidsfirstdocs.com

Consent for Release and Use of Confidential Information, Receipt of Notice of Privacy Practices Form, and Billing Information

I, ______________________________, hereby give my consent to Kids First Pediatrics, Ltd. to use, disclose,
(Print Name of Patient or Authorized Agent)
or release any medical information and copies of any medical records necessary to carry out treatment, process a related claim, or request payment of benefits directly to Kids First Pediatrics, Ltd.

I also authorize Kids First Pediatrics, Ltd. to release to my current and former insurance plans and any other physicians, any medical information and copies of medical records requested by those parties for the purposes including, but not limited to: office visits, hospitalizations, lab/medical testing, hospitalizations or insurance chart reviews.

For the purpose of patient communication, I authorize that Kids First Pediatrics, LTD has:

- ☐ No restrictions (e.g. May leave messages on answering machines, send email, etc)
- ☐ Restrictions (e.g. Direct person-to-person communication with parent/guardian ONLY

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me in the office or on the web site.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

The insured/responsible party will pay for any fees applied to a yearly deductible or co-pay. The insured/responsible party will also remit payment for any unpaid claims which are 60 days or more past due. It is the insured/responsible party's responsibility to know their individual insurance plan's benefits and the insured/responsible party agrees to pay all fees not covered by their individual insurance plan within 60 days of billing.

Signed: ________________________________ Date: ______________

Name of Patient: __________________________
(Please Print)

If you are not the patient, please specify your relationship to the patient

____

LATE POLICY

Understanding that life is not always predictable, and in an effort to respect the appointment times of all of our patients, we have implemented the following late policy:

1. If you are up to 15 minutes late for the scheduled visit, we will work you into the provider's schedule.
2. If you arrive later than 15 minutes after your scheduled appointment, you will be seen at the first available appointment time with the available provider. If no appointments are available for that day, you may be asked to reschedule.
3. If you arrive 15 minutes late to the scheduled sick appointment, the appointment may be rescheduled.

Please call ahead if you are running late, we will make every effort to accommodate you. If you need to cancel an appointment, we require a phone call 24 hours prior to your **scheduled** appointment. These appointments include, but are not limited to: well child exam, asthma exam/recheck, ADHD consultation/recheck, recheck of illness, and/or behavior consultation. Please remember that your appointment time has been reserved for you. There is a $25.00 fee for any appointment you miss or fail to cancel 24 hours prior to your **scheduled** appointment. Same day sick/injury appointments require a 4 hour cancellation notice. Once three failed appointments have occurred **within** the family, a reminder letter will be mailed. If an additional appointment is failed, then continuation of care at *Kids First Pediatrics* may be terminated at the office's discretion.

MINORS

Anyone under the age of 18 must have a parent present at all well check up and immunization visits. A release to treat a minor form signed for the day of the appointment will be accepted for sick appointments only.

Anyone under the age of 12 can not be left unattended in the waiting room.

Thank you for your understanding.

Steven Kovar, M.D.
Kristine Liberty, M.D.
Jessica Ciszek, M.D.
Taryn A. Vrasich, CPNP

Print name of patient ______ Print name of responsible party ______

Signature of patient/responsible party ______ Date ______

DOUBLE BOOK/SIBLING ADD ON APPOINTMENTS

Patients are seen at Kids First Pediatrics by appointment only. We require that you call ahead to schedule all appointments. While we understand that siblings may become ill unexpectedly and require medical evaluation, please remember that appointment times are reserved for each patient.

If you arrive at your child's appointment and ask the physician to see an additional child who is not scheduled, we will make every attempt to examine the sibling. There is an additional fee for any child examined without a scheduled appointment time. ***The fee is $50.00 per child that is examined without a scheduled appointment.*** The fee will be billed to your insurance company; however it is the policy's holder responsibility to ensure payment.

If an appointment time is available, your child will be scheduled at an appointment time without an added fee. Please note that the appointment time may not be at the same time as their sibling's. The physician will examine the scheduled patient and may need to leave the exam room to complete the scheduled appointments. The physician will then return to the sibling at the scheduled appointment time offered. If an appointment is unavailable we may not be able to examine your child.
We ask that you kindly respect those patients scheduled both before and after your child's appointment as we are trying to ensure that all of our patient needs are met.

PICTURES

Picture taking is allowed at Kids First Pediatrics during the exam only with the nurse and/or physician's consent. Picture taking is not allowed in the waiting room, hallway, or during any procedure/vaccine administration.

FORM/SERVICE FEES

Kids First Pediatrics will charge a $25.00 service fee for detailed forms. Examples include Family Medical Leave Act, Medical Leave of Absence, Workers' Compensation, Adoption, and Disability Forms. Please allow a minimum 24 hour turnaround time for completion of these forms.

Thank you for your understanding.

Steven Kovar, M.D.
Kristine Liberty, M.D.
Jessica Ciszek, M.D.
Taryn A. Vrasich, CPNP

____
Patient

________________________ ______________
Parent or legal guardian signature Date

The Benefits of Well-Child Visits:

Prevention: Your child will receive scheduled immunizations to prevent illness. You will also review nutrition, exercise, safety and family risk factors.

Growth and Development: During a well child visit we will monitor your child's growth physically, developmentally, socially and emotionally. You can discuss your child's milestones, social behavior and learning.

Team Approach: Regular visits create a strong, trustworthy relationship among pediatrician, parent and child. The AAP recommends well child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps to develop the physical, mental and social health of a child.

Raising Concerns: The well child visit is also a time for parents to discuss concerns regarding their child's physical, developmental, social and emotional growth, as well as review and update any chronic health issues. The providers at Kids First Pediatrics work closely with parents and specialty physicians to promote continuity of care for our patients. For chronic health issues, such as asthma or ADHD, please be advised additional appointments may be necessary to ensure adequate monitoring of your child's medications and progress.

Well child visits are scheduled based on the guidelines from The American Academy of Pediatrics. Please note that this schedule may vary from the one devised from your insurance company. The AAP recommends a well child visit at 1 week of age, 1 month, 2, 4, 6, 9, 12, 15, 18 and 24 months. While a 30 month visit is optional, after two years of age, a well child visit is recommended yearly until age 18. It is your responsibility to make these appointments in a timely manner to ensure that vaccinations are kept up to date.

We typically schedule well checks 366 days from the last well check to ensure insurance coverage for the visit. Please call your insurance company to verify your policy details prior to scheduling a well check as some policies cover well checks every calendar year while others require it to be at least 365 days from the prior well check.

To ensure the best care and safety of your child, please note that Kids First Pediatrics will not refill prescriptions, administer vaccines, complete school/sports forms or order labs and additional testing without a current well child visit (within the past 11 months).

MINORS: ANYONE UNDER THE AGE OF 18 *MUST* HAVE A LEGAL GUARDIAN PRESENT AT ALL WELL CHECKUPS OR IMMUNIZATION VISITS. A RELEASE TO TREAT A MINOR FORM SIGNED FOR THE DAY OF THE APPOINTMENT WILL BE ACCEPTED FOR SICK APPOINTMENTS ONLY.

Anyone under the age of 12 cannot be left unattended in the waiting room.

Please remember to bring your insurance care, photo ID and a Credit Card to be kept on file at EACH visit. Photos of insurance cards can be emailed to billing@kidsfirstdocs.net if your insurance company does not provide a physical card.

Steven Kovar, M.D.
Jessica Ciszek, M.D.
Kristine Liberty, M.D.
Taryn A. Vrasich, CPNP

Patient Name: ______________________________

Parent Signature: ___________________________

Date: ______________________________________

DEVELOPMENTAL SCREENING EVALUATION

The **M-Chat** and **Ages & Stages Questionnaires (ASQ-3)** are developmental screening tools used to identify possible developmental delays in young children. Our office follows the guidelines put forth by the American Academy of Pediatrics (AAP) which recommends administering the **M-Chat** and **Ages & Stages Questionnaires (ASQ-3)**. Although the **M-Chat** and **Ages & Stages Questionnaires (ASQ-3)** are not required, the providers at *Kids First Pediatrics* highly recommend the completion of these forms as part of the well child check.

There are additional fees separate from your well child check that is billed to your insurance company. The fees include: the form, scoring, and interpretation for discussion with your provider. Please see your nurse or provider with any questions.

Thank you

______________________________ ____________________

Parent/legal guardian signature | Date

______________________________ ____________________

Patient's name | Date of birth

Refusal to vaccinate policy

Kids First Pediatrics follows the immunization schedule approved by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices at the Centers for Disease Control (CDC).

As stated by the CDC:

- "Benefits of vaccination include partial or complete protection against infection for the vaccinated person and overall benefits to society as a whole. Benefits include protection from symptomatic illness, improved quality of life and productivity, and prevention of death.
- "Vaccines are recommended for members of the youngest age group at risk for experiencing the disease for whom efficacy and safety have been demonstrated."

As stated by the AAP:

- "Millions of children have been protected against serious illnesses because they were immunized. Most childhood vaccines are 90% to 99% effective in preventing disease. When a large majority of children have been vaccinated, it is expected that most who get the disease will have been vaccinated. And if a vaccinated child does get the disease, the symptoms are usually milder with less serious side effects or complications than in a child who hasn't been vaccinated."

While we respect that your beliefs may differ from those of the staff at Kids First Pediatrics, we can not risk the health of our other patients or staff members due to unvaccinated patients who can spread diseases.

It is our policy that all patients of Kids First Pediatrics must begin their immunizations no later than two months of age or within two months from your initial visit. An alternative vaccine schedule must be discussed and agreed upon with your provider. Please be advised that if you choose not to immunize your child, we will ask that you find a physician or provider that will accommodate your needs.

Thank you for your understanding.

Steven Kovar, M.D.
Kristine Liberty, M.D.
Jessica Ciszek, M.D.
Taryn A. Vrasich, CPNP

Kids First Pediatrics Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of underimmunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Kids First Pediatrics.** Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

During your office visit, your medical provider will discuss the risks and benefits of the recommended vaccines to be administered. Once you have given verbal permission to vaccinate your children, you are financially responsible for all supplies and immunization materials. We cannot guarantee coverage of services or procedures provided due to the complexities of the insurance contracts. You have the right to refuse vaccination. If you choose to deny vaccination after the vaccine has been prepared, you are responsible for all materials associated with vaccine administration. Vaccine handling and storage are followed per the manufacture guidelines. Therefore, vaccines that are disposed of due to a parent refusal after initial verbal agreement and permission will be billed directly to the patient.

Name of first child	Name of second child
Name of third child	Name of fourth child
Signature of legal guardian	Date
Print Name	

Patient Name: ________________________________ DOB: ____________________

I-CARE

I-CARE, or Illinois Comprehensive Automated Immunization Registry Exchange, is a web based immunization record-sharing application developed by the Illinois Department of Public Health (IDPH). The application allows public and private healthcare providers to share the immunization records of Illinois residents with other physicians statewide.

The main features include:

- Calculation of immunization due dates
- Automatic population and printing options for the school physical form and patient immunization history report
- Remind/Recall feature to track and notify patients of due dates
- Vaccine inventory feature to track vaccine usage by lot number
- Ability to record patient contraindications, adverse reactions, or immunities
- Assessment of immunization coverage levels by practice
- Temperature Log feature to track and report vaccine storage by appliance
- Vaccine Information Statement (VIS) module containing up to date VIS forms for printing, distribution, and tracking

Besides keeping track of the immunizations a child has already received, I-CARE forecasts immunization due dates based on the nationally recognized "Recommended Childhood Immunization Schedule." These recommendations are approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians.

What Is the Purpose of I-CARE?

I-CARE is designed to help healthcare provider's record, track, and report their patients' immunizations. The registry allows physicians to access patient records for information about immunizations administered outside their practices. Provider participation is voluntary and not all providers within the state choose to participate in the registry. Patient participation is also voluntary. Patients wishing not to have their information included in the registry may opt-out at their provider.

What About Security and Patient Confidentiality?

I-CARE is designed to protect patient confidentiality while providing access to statewide registry information. Confidentiality is maintained through several security controls. Open access to the statewide registry is not allowed. Only registered I-CARE users have access to the data and information is available only on a need-to-know basis. In other words, an I-CARE user cannot browse through patient records. Specific name or ID search criteria must be used to access information in the statewide registry.

To learn more, please visit http://www.dph.illinois.gov/.

_____ I consent to participate in the I-CARE Registry

_____ I choose to opt out of the I-CARE Registry

____

Signature of Patient/Responsible party   Date:

Telemedicine at Kids First Pediatrics

Telehealth, or a "virtual visit", is a consultation with one of our physicians via video conferencing.

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 perform a physical exam, we may not be able to fully evaluate their complaint, such as ear pain or coughs, in a virtual visit. Also, 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. While maintenance exams for ADHD or well controlled asthma may be appropriate, well exams and, as stated above, some sick visits are not appropriate for telehealth. Our providers 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 by calling our office and speaking to one of our staff members. 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.

We will bill your insurance company, as we do with other visits, and like those, you will be responsible for the balance.

<u>How to join a call that has been scheduled for you</u>

We are providing video conferencing through Doxy.me, a free 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, a link will be sent as a text from Doxy.me to the number provided at the time the appointment was scheduled. In order to proceed with the telehealth visit, this form will need to be completed.

______________________________ ______________________________

Signature Date