Willow Tree Pediatrics of Lexington
2036 Regency Road, Ste 2 Lexington, KY 40503
859-286-9046

DEMOGRAPHICS AND INSURANCE

Patient's Name:

_____

First **Middle** **Last**

Address: _____**City**:_____**State**:_____ **Zip**:_____

DOB:_____ **Gender** ☐**Male** ☐**Female** **Social Security #**:_____

Race: ☐**White** ☐**Hispanic** ☐**Black or African American** ☐**Asian** ☐**Decline to Report** **Other:**_____

Ethnicity: ☐**Hispanic or Latino/a** ☐**Not Hispanic or Latino/a** ☐**Decline to Report** **Other:**_____

Parent/Guardian #1: Name:_____ **Relationship to minor**:_____

Cell Phone:_____ **Date of Birth:**_____

Email:_____

Parent/Guardian #2: Name:_____ **Relationship to minor:**_____

Cell Phone:_____ **Date of Birth:**_____

Email:_____

Preferred Pharmacy:_____ **Phone #**:_____

Whom may we call in case of an emergency? Name:_____

Relationship to patient:_____ **Primary Phone #:**_____

How did you hear about us? ☐**Family/Friend** ☐**Social Media** ☐**Google Search** ☐**Other:**_____

_____

Insurance Information

Please list ALL insurance information and plans the parent/guardian has had within the last calendar year.

Primary Insurance Company:_____ **Insurance Phone #:**_____

Subscriber Name:_____ DOB:_____ SS#:_____

Insurance ID:_____ Group #:_____

Patient Relationship to Subscriber:_____

Secondary Insurance Company:_____ **Insurance Phone #:**_____

Subscriber Name:_____ DOB:_____ SS#:_____

Insurance ID:_____ Group #:_____

Patient Relationship to Subscriber:_____

Did you have previous insurance for the current calendar year? **Yes / No**

If yes Insurance Name:_____Date Coverage Ended:_____

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PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Name of Person Completing Form: _____ Relation to Patient:_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, etc.*

Medication Name	Dose	Frequency

***** If you are on 5 or more medications – please bring them with you to each appointment. *****

ALLERGIES: *List all reactions to medicines, foods and other agents*

Allergy	Reaction or Side Affect

REVIEW OF SYSTEMS: *Please indicate with a check (√) any **current or ongoing** problems your child has on the list below*

CONSTITUTIONAL

- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss
- Fatigue/weakness
- ☐ Excessive thirst or urination

CARDIOVASCULAR

- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

NEUROLOGICAL

- ☐ Headaches
- ☐ Dizziness/light-headedness
- Numbness
- ☐ Memory loss
- ☐ Loss of coordination

EYES

- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

GENITOURINARY

- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Discharge from penis

GYNECOLOGICAL

- ☐ Abnormal vaginal bleeding
- ☐ Vaginal discharge

☐ Vaginal odor

EARS/NOSE/THROAT/MOUTH

☐ Difficulty hearing/ringing in
☐ Hay fever/allergies
☐ Problems with teeth/gum

RESPIRATORY

☐ Cough/wheeze
☐ Difficulty breathing

MUSCULO-SKELETAL

☐ Muscle/joint pain

SKIN

☐ Rash or mole change(s)

PSYCHIATRIC

☐ Anxiety/stress
☐ Problems with sleep
☐ Depression
☐ ADHD

OTHER: _____
_____

HOSPITALIZATIONS: *Please list all prior hospitalizations and dates.*

Reason	**Hospital / Clinic Name**	**Date**

SURGERIES: *Please list any surgeries, location, and dates.*

Surgery	**Hospital / Clinic Name**	**Date**

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Stepchild □Other: _____ Were there any medical problems during pregnancy? □ Yes □ No If yes, please explain: _____
Were there problems during labor and delivery? □ Yes □ No If yes, please explain: _____
Were there problems such as needing oxygen, trouble breathing, jaundice (yellowness), after the patient's birth? □ Yes □ No
If yes, please explain: _____

Where was the patient born? _____ Method of Delivery: □ Vaginal □ Cesarean Birth
Weight/Length: ____lbs. _____oz. _____inches Was your child born prematurely? □ Yes □ No If yes how early: _____
For Male Patients Only: Is your child circumcised? □ Yes □ No

SLEEP:

How many hours a night does the patient sleep? _____
How many naps does the patient take per day and length of naps? _____
Does the patient have any sleep problems? □ Yes □ No If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: □Breastfed □Formula. If breastfed, for how long? _____
Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: _____
_____
Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify: _____,
# of ounces of milk per day _____
Has the patient seen a dentist? □ Yes □ No If yes, date of last visit _____.
What is the water source at the house? □ City □ Well

DEVELOPMENT:

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themself? □ Yes □ No If yes, please explain: _____

Are there any areas of concerns about language or speech development? □ Yes □ No If yes, please explain:

_____

Has your child ever been to occupational, physical, or speech therapy? □ Yes □ No If yes, please explain:

_____

When the patient is in the car, do they use: □ Infant Seat □ Booster Seat □ Seatbelt Only

Does the patient wear a helmet while riding a bike? □ Yes □ No

Do you have concerns about the patient's behavior at home or in groups with other children? □ Yes □ No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period _____ Any issues / concerns?_____

SOCIAL HISTORY:

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced If divorced, for how long? _____

Mother's Employer: _____ Mother's Occupation: _____

Father's Employer: _____Father's Occupation: _____

Do any household members smoke? □ Yes □ No Is violence in the home a concern? □ Yes □ No

Are there guns in the home? □ Yes □ No

Would you like to speak with the physician regarding the patient's: □ Alcohol Use □ Tobacco Use □ Sexual Activity □ Aggressive Behavior

How many hours per day does the patient spend with the following: ___Watching TV ___On the Computer/iPad ___Playing Video Games

Do you have any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? □ Yes □ No

Do you have smoke detectors in your home? □ Yes □ No

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? □ Yes □ No Current grade in school? _____

Name of School Attending:_____

Do you have concerns with how the patient is doing in school? □ Yes □ No

Any concerns about relationships with teachers or other students? □ Yes □ No

Does your child play any sports? □ Yes □ No How many times a week? _____ How long (minutes) _____

Who lives at home with the patient?

Name	Date of Birth	Relationship

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Substance Use Problems	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

PREVIOUS PEDIATRICIANS: *Please list the names, address and phone numbers below of previous pediatricians the child has seen from birth until current age.*

Practice / Doctor Name	Address	Phone Number

_____ _____

Parent / Guardian Signature Date

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____ 1. CONSENT FOR TREATMENT & PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby consent to examination and treatment by Willow Tree Pediatrics of Lexington, including diagnostic and/or other procedures ordered by the provider.

I acknowledge that Willow Tree Pediatrics of Lexington has provided me with a written copy of their Notice of Privacy Practices, if so requested. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions, which explains how my medical information will be used and disclosed.

____ 2. ASSIGNMENT OF BENEFITS

I authorize direct payment of benefits provided under any health care plan or medical expense policy due to me or payable on my behalf to Willow Tree Pediatrics of Lexington. I further authorize release of information required by any third party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third party payor, as defined under my plan benefit contract, are my responsibility.

____ 3. PAYMENT

I accept financial responsibility for payments for all services and products received. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card. I also understand there will be an additional $50.00 processing fee for collection accounts and bounced checks for each date of service. For payments made over the phone, I understand Willow Tree Pediatrics of Lexington will charge a flat rate convenience fee. For balances $0.00-$99.99, the fee is $3.00, balances of $100.00-199.99, the fee is $6.00 and, $200.00 and greater, the fee is $10.00.

____ 4. PATIENT AUTHORIZATION

I authorize Willow Tree Pediatrics of Lexington to send copies of my records to other providers as needed for continuity of care. I also agree that Willow Tree Pediatrics of Lexington can release my records to accrediting or regulatory agencies, if those agencies request my records and if the law allows these agencies to see my records.

____ 5. AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

I authorize Willow Tree Pediatrics of Lexington to leave messages on my answering machine, voicemail, or with individuals who answer the phone numbers provided on the patient registration form. Willow Tree Pediatrics of Lexington will share private health information with authorized individuals. I authorize Willow Tree Pediatrics of Lexington to contact me by automated SMS text messages for appointment reminders. I understand that message/data

rates may apply to messages sent by Willow Tree Pediatrics of Lexington under my cell phone plan.

I know that I am under no obligation to authorize Willow Tree Pediatrics of Lexington to send me text messages. I may opt-out of receiving these communications at any time by calling the office at (859) 286-9046. Please allow 5-7 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information and other sensitive or confidential information contained in such text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of provider, and provider phone number, or other other pertinent information. By signing below, I indicate that I am the primary user for the mobile phone listed on the registration form. I accept the risk explained above and consent to receive text messages via automated technology from Willow Tree Pediatrics of Lexington to the phone number I have provided.

____ 6. FORMS

As you know, many changes have taken place in the healthcare industry. Amongst these changes is the rise in administrative costs of operating a doctor's office. Services that were once covered by insurance are not either partially covered, covered under certain medical necessities, or not covered at all. We want to continue to provide the highest quality of medical care to our families, but unfortunately, this includes providing services that are no longer covered by your insurance company. Over the past several years, Willow Tree Pediatrics of Lexington has absorbed the cost of these non-covered services. In the current environment, this has become unsustainable. For any forms, such as, letters to schools for your child's needs, completing health forms for school / camp / sports forms / immunization records, etc. The cost for these forms are based on the complexity and can range from **$30.00-$100.00**. I understand this fee is due upon receival of the form.

____ 7. WELL CHILD VISITS

To ensure the best possible care for your child, we ask that you attend all scheduled well-child visits in accordance with the American Academy of Pediatrics' recommended schedule. These visits are essential for immunization counseling, disease detection, growth and development monitoring, and establishing a strong relationship between your family and our healthcare provider. In the event that you choose to miss **1** scheduled visit, we will provide written notification of our need to dismiss you from our practice at Willow Tree Pediatrics of Lexington.

____ 8. VACCINE POLICY

Willow Tree Pediatrics is a vaccine-friendly environment and believes that parents should be free to select the best "medical home" for their children, regardless of one's philosophy on vaccination. We fully endorse the CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger. We do not recommend anything other than the CDC Recommended Child and Adolescent Immunization

Schedule for ages 18 years or younger. If you decide to do anything less than the recommended schedule, we will respect your wishes but you acknowledge your decision and its risks are solely your responsibility and that we are not accountable for any adversity should your

child suffer from a disease for which there is a vaccination. I have read and acknowledge this statement.

____ 9. PATIENT PORTAL AGREEMENT

By accessing and using the portal, you are indicating your acceptance and confirm that you have read, understood, and agree to be bound by the terms and conditions of this Agreement and the related Notice of Privacy Practices. If you do not accept these terms and conditions, your immediate remedy is to not access or continue to use the portal.

In this agreement, you understand that the portal is not meant to be used in case of an emergency. For all matters requiring urgent care, which you believe may negatively impact your child(s) health or well-being, you understand that you must call 911 or proceed to the nearest emergency department.

This Patient Portal is provided as a courtesy to our patients. You will receive an email to login and gain access to your child's account after your first visit. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

In the patient portal, there are many features you can utilize, such as viewing medical records, such as lab results, direct messaging, accessing immunization records, and seeing upcoming appointments.

If needed, you can message our medical assistant(s) directly through the portal with any questions you may have in regards to your children's care. Messages will be directed to the medical assistant on staff for review. Patient-initiated digital communications provided by the provider fall under online digital evaluation services, or e-visits. **Therefore, if you receive a response directly from the provider for medical advice your insurance will be billed which often requires a copay**. With direct messaging, I understand that it can take 24-48 business hours to receive a response.

Please initial each statement and sign below. By signing below, I attest I have read the above and authorize Willow Tree Pediatrics of Lexington, to treat, bill, and share my medical information as discussed above.

_____	_____
Signature of Patient/Parent or Guardian(if minor)	**Name of Patient/Parent or Guardian (if minor)**
_____	_____
Date	**Relationship to Patient (if minor)**

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APPOINTMENT CANCELLATION/ NO SHOW POLICY

Thank you for trusting your medical care to Willow Tree Pediatrics of Lexington. When you schedule an appointment with Willow Tree Pediatrics of Lexington, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation / No Call No Show Policy below.

- Effective January 1, 2025, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be charged a **$50.00 fee.**

- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second** time will be charged a **$75.00 fee**.

- If a patient accumulates a **third** cancellation/reschedule without a 24 hour notice, a **$75.00 fee** will be assessed and the patient may be dismissed from Willow Tree Pediatrics of Lexington.

- The fee is charged to the patient, not the insurance, and is **due before the patient can be seen again in the office.**

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Administrative Assistant: who may be able to waive the No Show fee. You may contact Willow Tree Pediatrics of Lexington 24 hours a day, 7 days a week at the number above. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message to cancel your appointment.
I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____
Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____
Printed Name Date

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Well Visits and Office Visits

Well baby and well child visit definition - “Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.” -Healthcare.gov

Office visit definition - An appointment designed to discuss new or existing health issues, concerns, worries, or symptoms. Your provider may order tests, prescribe medication, refer you to a specialist or provide advice and education. Office visits are covered by a standard insurance copay or deductible.

Please read and initial that you understand and agree to the following:

_____I understand that I may receive a bill for an office visit during a well visit appointment if the appointment meets any of the criteria of the office visit definition mentioned above.

_____I may receive a bill if my child's insurance plan is not ACA-compliant. While new group health plans and exchange plans are required to cover all parts of the well child visit with no cost sharing, many health insurance plans are exempt from the ACA and, as a result, this requirement. These include existing unchanged health plans from before the ACA became law ("grandfathered" plans), federal employee plans, government plans like Tricare or ChampVA, ERISA-based self-insured plans, and membership plans like faith-based cost-sharing services.

_____ I may receive a bill if my child's insurance plan is ACA-compliant, but my child(ren) received some preventive services which are not part of the ACA-recommended list.

The list of services that ACA-compliant plans are expected to cover can be found at the US Preventive Services Task Force. For example, routine vaccines—not travel vaccines—are in the list of covered preventive services. If a child received a travel vaccine as part of a well-child visit, an ACA-compliant plan may not full cover the cost of the travel vaccine (even though it is a preventive service).

_____I may receive a bill if my child's insurance plan is ACA-compliant, but my child(ren) received some non-preventive services as part of the visit. Well visits are intended for covered **preventive** services only.

Some examples of items that are NOT a part of a well visit are rapid strep test for strep throat or evaluation of chronic headaches done at a well-child visit. While both of these services help promote wellness, neither are included in the definition of a standard well-child visit service and will result in an additional charge based on the rules of your insurance plan. We encourage patients to schedule a separate visit(unless it is an acute issue) for issues outside of the well visit so that the provider may set aside the time needed for the issues.

_____I may receive a bill if my child's insurance plan is ACA-compliant, but my child(ren) receive more frequent services than is typical.

This occurs when well-child visits are scheduled closer together than what the insurance company considers to be "annual." Some insurance companies pay for one well child visit per calendar year. This means a child might have a check-up in September one year and July the next. Other insurance companies have more stringent rules and say that at least 365 days must pass between well exams. If not, the second well visit will be denied by your insurance company, and you will be responsible for the charge. Be sure you understand your insurance company's definition of "annual" before scheduling the appointment.

_____ _____

Parent / Guardian Signature Date

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NEWBORN INSURANCE VERIFICATION

Dear Parent,

Congratulations on the birth of your new baby, and welcome to **Willow Tree Pediatrics of Lexington**! We are honored to care for your family.

To ensure that your child's visits are billed correctly, please complete this form **before or during your first visit**. Accurate and timely insurance information is essential.

Important Insurance Information

- **You must add your newborn to your insurance policy within 30 days of birth.**

- Please note that **Kentucky law does not require a birth certificate to add your newborn to your insurance policy**. However, **your employer or insurance carrier may require documentation of birth** (such as a birth certificate or hospital birth record) to complete enrollment. Requirements vary by plan. We recommend contacting your employer's HR department or insurance carrier promptly to confirm what documentation is needed so coverage is not delayed.

- Please provide **copies (front and back) of all applicable insurance cards** at your first visit.

Failure to add your child within the 30-day window may result in denied claims and out-of-pocket charges.

Patient & Insurance Information

Child's Full Name: _____

Mother's Name & Date of Birth: _____

Mother's Insurance Company: _____

Policy Number: _____ Group Number: _____

Father's Name & Date of Birth: _____

Father's Insurance Company: _____

Policy Number: _____ Group Number: _____

Which insurance plan will your child be added to?_____

Acknowledgment & Financial Responsibility

_____ **I acknowledge that once my child is 30 days old, Willow Tree Pediatrics must be able to verify active insurance coverage in my child's name.**
If coverage cannot be verified:

_____ I understand that **I am financially responsible for any charges related to visits during the first 30 days**, and

_____ Any future visits will be **self-pay** until insurance coverage is active.

_____ I authorize Willow Tree Pediatrics to charge the balance due to the credit card listed below on the **31st day of life**, if insurance has not been added or verified.

Credit Card Authorization

Credit Card Number: _____
Expiration Date (MM/YY): _____
Security Code: _____
Email Address for Receipt: _____

If you have questions or need help navigating your insurance enrollment, our staff is happy to assist. Thank you for helping us keep your child's care running smoothly—we look forward to meeting you and your new baby!

Warmly,

Willow Tree Pediatrics of Lexington

Willow Tree Pediatrics of Lexington
2036 Regency Road, Ste 2 Lexington, KY 40503
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Authorization to Release Healthcare Information

I hereby authorize_____or its agent(s) to disclose my health Information as described in this authorization:

Patient Name:_____Date of Birth:_____

Please release health care information to/from:

Willow Tree Pediatrics of Lexington
2036 Regency Road Suite 2
Lexington, KY 40503

If medical records are more than 25 pages, including the fax cover sheet, please mail them to the address above. Since we only have one fax machine, we cannot accept large faxes.

Release the following information:

- ☐ Patient's Entire Medical Record
- ☐ Consultation Note
- ☐ Progress Notes for the last _____ visits/months
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Imaging Results
- ☐ Procedure/Operative Reports
- ☐ Other:_____

I understand that this authorization expires a year from the date signed. I understand I can obtain one free copy of my child's medical records. After that free copy has been utilized, it will cost $1.00 per page. I understand I have the right to revoke or cancel this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be subject to the recipient and no longer be protected by Federal Privacy Regulations. By signing this authorization, I request my child's records to be released to the practice listed.

_____ _____

Signature of Parent/Guardian Today's Date